

APPG inquiry appeals to pharmacists for evidence

Ordinary pharmacists have been encouraged to tell the All-Party Pharmacy Group what they think the future of pharmacy should hold.

Outlining the direction of the group's inquiry into the future of pharmacy, group chairman Howard Stoate (Lab, Dartford) said this week: "We really want to hear from workaday pharmacists about what are the difficulties, what the challenges are and whether they've got any great ideas that nobody is listening to." Nobody should be put off by the questionnaire — which is accessible via *PJ Online* (www.pjonline.com/links/pj) — that is being used as a starting point for the inquiry, Dr Stoate added. The group wants to hear from pharmacists even if they only want to answer one question.

Dr Stoate said that the aim is to encourage more thinking about the development of pharmacy services. "We don't want just to hear about some of the problems, we want to

hear about solutions as well," he said. "We aim to challenge policymakers and the profession to increase the rate of development and to think radically about those developments."

To do this, the group wants to get evidence from a broad range of stakeholders, such as patients, the nursing and medical professions, the Department of Health, primary care trusts, health trusts, think-tanks and Parliamentary colleagues, as well as pharmacists.

However, Dr Stoate emphasised that the group did not exist to do the profession's bidding. "We are here for the good of pharmacy, for the good of patients and for the good of health care. We are not just going to act as a mouthpiece for the profession. This is very much aimed to challenge people, including the Government and including pharmacists."

He added: "I think the Government is keen to engage. We all know the health service has got problems and I think they want

pharmacy to be a bigger part of the solution." Sandra Gidley (LibDem, Romsey), the group's treasurer and a pharmacist, said: "The opportunities provided by the pharmacy contract [in England] have not been realised. It is difficult to tell whether that is because of the lack of ambition from the profession or because there are barriers."

A wide range of groups will be invited to give evidence to the inquiry and DoH officials will be invited to the evidence sessions to hear what is being said. The focus of inquiry will be on the future of pharmacy in England, but the group wants to hear from pharmacists in Scotland and Wales about what is being done there. "We also want to invite pharmacists and pharmacy officials from Scotland, because they do things very differently," said Mrs Gidley. "Some of the early feedback we've had is that their contract is easier and has promoted change faster."

Concern mounts over job security in PCTs

Pharmacists and other head office staff in primary care trusts across England are facing uncertainty over their futures in the run up to the reorganisation of PCTs. Last week, PCT staff classed as managers or administrators in Devon and Cornwall received a letter formally informing them that their jobs are potentially at risk.

Shailen Rao, head of medicines management at Hillingdon PCT and chairman of the Primary Care Pharmacists Association, told *The Journal* that there is a debate at the moment about where prescribing teams will sit after the reconfigurations.

"PCTs may wish to share strategic functions but may underestimate the need for strategic input in individual PCTs."

He added that the arrival of practice-based commissioning and transfer of services from secondary to primary care will require greater input from primary care pharmacists to ensure that medicines management initiatives are supported. Mr Rao is also concerned that laying off pharmacy staff could be a false economy and that a wealth of knowledge and experience may be lost in the process.

Brian Curwain, chief pharmacist at New Forest PCT and a member of the Royal Pharmaceutical Society's Council, told *The Journal* that in Hampshire seven PCTs are merging to form one organisation. "There are five senior grade pharmacists within the seven PCTs. My guess is that there won't be five jobs at that level within the new organisation." He and his colleagues have already started working on a proposal for pharmaceutical support to the reconfigured PCT.

Dr Curwain predicts that the reconfiguration will not lead to job losses overall but that significant numbers of people might have their employment changed in one way or an-



Brain Curwain: danger of isolation

other. "For example, budgets currently funding PCT medicines management teams might be devolved to practice-based commissioning groups to buy local pharmaceutical support," he says. He believes that if existing teams fragment, there is a danger of professional isolation and variable quality. "If this happens, those providing support to PCT pharmacists, such as the National Prescribing Centre, will have to ensure that they nurture their networks," he added.

Reconfigured PCTs come into being on 1 October. *The Journal* understands that staff redundancies in Devon and Cornwall will be kept to an absolute minimum and, if suitable posts cannot be found for individuals, employment will be guaranteed until 30 June 2007. Staff providing front-line services will not be affected.

Unscheduled care payments announced in Scotland

Community pharmacists in Scotland are to receive funding in recognition of the pressures they face in the out-of-hours period. An overall sum had been promised as part of the new pharmacy contract deal and this week it was announced how the sum will be distributed among contractors.

Details of the funding, called "unscheduled care payments", are set out in an NHS circular. The Scottish Executive says the payment is to cover "demands arising from recent changes to the pattern of primary medical services and patient referrals by NHS24".

An integral part of the unscheduled care provisions is the patient group direction (PGD) that allows pharmacists to make urgent supplies of medicines in the out-of-hours period (*PJ*, 3 December 2005, p682). However, the unscheduled care payments will not be linked to use of the PGD but be paid on the basis of the number of hours a pharmacy is open. The payment scale ranges from pharmacies open more than 30 hours per week down to those open for between five and 10 hours a week. Pharmacies open for more than 30 hours a week will receive an annual payment of £1,260.

Alex MacKinnon, head of professional services development communication and external relations at the Scottish Pharmaceutical General Council, said that the payment is good news. "It is important it is not tied to the PGD because that is a professional tool," he commented. Mr MacKinnon explained that the payment will be reviewed after a year. "We need to quantify the workload over the next year and identify exactly what the fall-out from the GP contract means for community pharmacy. But this is a fairly reasonable first attempt," he said.

NPA concerned about 100-hour exemption abuse

Concerns about exploitation of the 100-hour exemption rule under NHS pharmacy control of entry reforms have been raised by the National Pharmacy Association.

"This is now being used as a means of circumventing the necessary or desirable test," it says.

The NPA is aware of a number of 100-hour exempted sites — particularly in or adjacent to existing GP surgeries — where the use of the 100-hour exemption is causing problems for local contractors. "The position is exacerbated by the unwillingness or inability of some PCTs to monitor the 100-hour requirement," it adds. The NPA believes that a robust monitoring framework is essential to prevent abuse of the exemption.

The NPA welcomes the Government's review of control of entry reforms and assessment of the progress in implementing the "balanced package of measures" introduced in April last year.

Umesh Patel, chairman of the NPA, said: "It is still relatively early to perform a full assessment of the impact of the balanced package of measures. However, the NPA still holds



Umesh Patel: contract controls ensure rational distribution

the view submitted as part of its original submission that control of entry is needed to ensure that there is a rational distribution of

pharmacies and to ensure that patients enjoy ready and easy access to pharmacy services from their surgery, and where they live and work." He added that this is currently the case, but the NPA is concerned that any weakening of the current controls — and any exploitation of the exemptions in a manner that undermines the basic principle of basing contracts on necessity and desirability — may serve to weaken the widespread access to services and thus disadvantage consumers.

The NPA will respond to the Government's review and is encouraging its members to get involved. It will be contacting a random sample of pharmacists to ascertain the impact of the reforms on local pharmacy services. A questionnaire has been prepared to assist with this. NPA members who have not received the questionnaire and who would like to participate can contact the business team on 01727 858687, extension 3204 or e-mail pharmacybusiness@npa.co.uk.

Pharmacists who want to contribute to the Government's consultation directly can do so until 12 September 2006.

Section 60 threatens professional support

Plans for the future regulation of pharmacy by the Royal Pharmaceutical Society will lead to a reduction in the Society's professional and supportive roles.

This is the view of the Institute of Pharmacy Management International set out in its response to the Government's consultation on the proposed Section 60 Order (*PJ*, 1 April, p371).

The IPMI says that the Society has a good record as a regulator across all areas of practice and investigates proportionately more members than either the General Medical Council or the Nursing and Midwifery Council. It also says that the Society's regulatory cost per member is double that of the GMC and NMC and that costs will rise.

The IPMI adds that pharmacy is unique among health professions in that pharmacy businesses are also regulated and, yet, there is

no facility to warn the public when a business is performing poorly and that this could be more important than for a poorly performing pharmacist. It proposes a separate disciplinary committee to deal with business offences.

The IPMI shares the Society's view that registration as a pharmacist and Society membership should remain linked. It is concerned that breaking the link could lead to additional costs. It says that if the proposal is serious, then it should be considered separately and with proper debate and that if carried through, then the profession's resources should be retained for the benefit of members.

The IPMA also believes that the proposed definition of a practising pharmacist is over-restrictive and that the proposals for continuing professional development have cost implications that must be funded.

AAH training programme

AAH Pharmaceuticals is to offer a training programme for preregistration graduates from October.

The programme, provided by Buttercups Training, is aimed at trainees working in independent pharmacies, although multiples without an in-house training programme can also make use of the course. It will provide seven days of training over 10 months.

Preregistration information

NHS boards in Scotland are being asked by the Scottish Executive to provide information about pharmacy preregistration places within their board area. Details required include the names of students, locations of placements and level of funding provided by boards to community pharmacy contractors.

New arrangements for preregistration places are to be introduced next year, with top-up funding to be paid this year, and the details requested will inform this process.

New oxygen suppliers may not meet 1 August deadline

Some pharmacists may still be required to dispense oxygen after 1 August, when the formal transition period to the new service arrangements ends, the Pharmaceutical Services Negotiating Committee said this week.

In a statement on its website, the PSNC said that the regional suppliers are working to assume responsibility for the supply of oxygen to patients in their service region by 1 August. However, "to ensure continuity of supply until all patients safely transfer to new

suppliers there may be a need for some pharmacies to continue to support service provision, for example, by not withdrawing full cylinders supplied or by dispensing oxygen against prescriptions, post 1 August, until a patient is handed over to the new supplier".

The PSNC also confirmed that contractors will continue to be reimbursed for the cost of gas and the rental of non-Drug Tariff size cylinders and for services to oxygen patients, including the collection and delivery of cylinders through local arrangements.

In brief

Numark's practice diary

Numark has launched a professional practice diary for its members to help them record learning activities that happen within their day-to-day work. Alongside a standard diary layout, there are templates for recording details of learning opportunities such as interventions and near misses.

MPs says NPSA has not improved safety enough

Insufficient progress has been made in improving safety in the NHS over the past few years, according to a new parliamentary report.

"A safer place for patients: learning to improve patient safety", published by the House of Commons Select Committee on Public Accounts, says that, despite notable improvements in the development of a more open reporting culture in the NHS, under-reporting of safety incidents remains a problem.

The report says that some 974,000 patient safety incidents and near misses were recorded on NHS trusts' reporting systems in 2004-05, but trusts estimate that on average 22 per cent of incidents and 39 per cent of near misses go unreported. Medication errors and incidents leading to serious harm are thought to be the least likely incidents to be reported.

The report questions the value for money of the National Patient Safety Agency. When the NPSA was established, it was allocated a budget of about £15m. By 2004-05 this had increased to £17m, and in 2005-06, follow-



Susan Williams: NPSA has already acted

ing an increase in its remit, the budget was £35m. The report outlines progress made by the NPSA, including published guidance on

good practice in dealing with staff involved in incidents, training 8,000 staff in an accident investigation technique, and issuing guidance to chief executives in their role in promoting safety.

However, it highlights delays in establishing the National Reporting and Learning System (NRLS) and its overrunning costs, and says that the NRLS has not helped simplify reporting incidents for trusts.

According to the report, trusts generally perceive that the NPSA has failed to maximise learning because it has not provided feedback of solutions quickly and regularly. Furthermore, the NPSA is criticised for failing to evaluate and promulgate solutions that have been developed at trust level. The report also states that trusts have not done enough to tell patients when things go wrong or to involve them in developing solutions to incidents.

Susan Williams, joint chief executive of the NPSA, said: "The NPSA welcomes this report. The committee of public accounts acknowledges that progress has been made and we agree that more needs to be achieved to secure even safer health care in the NHS."

She said that the NPSA has already acted on a number of issues identified in the report and will work with the Department of Health to consider the report's recommendations carefully.

"The Agency remains committed to helping improve patient safety in the NHS and working with the local NHS to deliver this," she added. "A publications strategy has been agreed with the Department of Health and we plan to publish our second key report on safety incidents in the summer."

The report is accessible via *PJ Online* (www.pjonline.com/links/pj).

MPs' recommendations to improve patient safety

The House of Commons Select Committee on Public Accounts makes several recommendations including:

- The NPSA should compare its data with the incident reporting data collected by the National Audit Office. The Healthcare Commission should evaluate compliance with reporting requirements as part of its performance assessment process.
- The Department of Health, NHS Connecting for Health and the NPSA should agree a plan and timetable for rationalising the reporting routes.
- The NPSA needs to obtain a more precise understanding of the extent and causes of death and serious harm, and develop a more targeted risk-based approach to solutions.
- Trusts should evaluate their own levels of reporting and target training and feedback towards those groups less likely to make reports.

Financial failures of NHS trusts share common causes

Financial failure of NHS trusts cannot be separated from wider organisational failures, an Audit Commission report has concluded.

"Learning the lessons from financial failure in the NHS" looks at the 25 NHS bodies that were subject to public interest reports in 2005-06. Financial failures in them were the result of a common set of causes, the report argues, including inadequate leadership (particularly in the posts of chief executive and finance director), lack of cohesion at board level, distractions caused by short-term projects and the disengagement of senior clinicians.

However, the Audit Commission believes that the road to recovery lies in simply reversing these areas of weakness. "The reintroduction of sound governance, financial, corporate and clinical, following a failure can result in an improvement in patient care," its report says.

Regular paracetamol may reduce ovarian cancer risk, but further studies are needed

Regular paracetamol use is associated with a 30 per cent reduction in risk of developing ovarian cancer, according to the authors of a meta-analysis published in the *British Journal of Clinical Pharmacology* (2006;62:113). However, they warn that the association cannot yet be regarded as one that should prompt a public health recommendation.

Stefanos Bonovas, from the University of Athens, and colleagues analysed eight studies published between 1998 and 2004 and involving 746,000 women, 4,405 of whom had ovarian cancer.

Statistical analysis revealed an inverse relationship between paracetamol use and ovarian cancer risk (relative risk 0.84, 95 per cent confidence interval 0.70-1.00). Regular use, defined as the highest frequency of drug use reported in the individual studies, reduced

the risk of developing ovarian cancer compared with non-use (RR 0.70, CI 0.51-0.95). Irregular use was not associated with a reduction in risk.

The researchers say that the risks of long-term use of paracetamol, ie, liver and chronic renal failure, may outweigh the potential benefits in preventing ovarian cancer in populations at low risk. They suggest that a randomised controlled trial of paracetamol might be appropriate in high-risk populations. However, they question whether epidemiological evidence provides a firm basis for this, especially when it comes from sparse and heterogeneous trials.

"Laboratory investigations should be conducted to define further the biological mechanism by which paracetamol may influence risk," they conclude.

Latest medicines assessed by SMC all accepted

Tigecycline (Tygacil) has been accepted for restricted use within NHS Scotland in the latest round of recommendations released by the Scottish Medicines Consortium. The SMC has restricted the use of tigecycline to second-line treatment of complicated intra-abdominal infection, and to second- or third-line treatment of complicated skin and soft-tissue infections, under the advice of local microbiologists or infectious disease specialists (in both cases).

The SMC has also approved rosiglitazone/metformin (Avandamet) tablets for use in combination with a sulphonylurea for patients (particularly those who are overweight) who are unable to achieve sufficient glycaemic control with dual oral therapy and are unable or unwilling to take insulin. The SMC recommends that the "triple therapy" be initiated and monitored by physicians experienced in treat-

ing diabetes patients. Rosiglitazone/metformin was approved for use in type 2 diabetes by the SMC last year (*PJ*, 15 January 2005, p40); the updated guidance is for the additional triple therapy indication.

Cetuximab (Erbix) has also been reviewed by the SMC and accepted for use in Scotland in combination with radiation therapy for patients with locally advanced squamous cell cancer of the head and neck. The SMC is restricting cetuximab to use by head and neck cancer specialists for patients who are cannot be treated with chemoradiotherapy and who are without evidence of distant metastases.

Ropinirole — recently relaunched as Adartrel by GlaxoSmithKline for the treatment of moderate to severe restless legs syndrome (*PJ*, 20 May, p588) — has been re-examined by the SMC and approved for

the new indication. The SMC says that ropinirole should be restricted to use in patients with a baseline score of 24 points or more on the international restless legs scale.

The following products have also been accepted by the SMC: dinoprostone (Propess) 10mg vaginal delivery system — the new pessary formulation which can remain in place for 24 hours (*PJ*, 24/31 December 2005, p771) — for initiation of cervical ripening in patients at term (from 38 weeks of gestation); testosterone gel (Testim) as replacement therapy for adult male hypogonadism with testosterone deficiency confirmed by clinical features and biochemical tests; and clobetasol propionate 0.05 per cent cutaneous foam (Clarelux) for short-course treatment of steroid-responsive dermatoses of the scalp, such as psoriasis, which do not respond satisfactorily to less potent steroids.

Additional safety information issued for infliximab

Additional safety information for the tumour necrosis factor inhibitor infliximab (Remicade) has been released by the drug's manufacturer.

In a "Dear health care professional" letter dated 7 June, Schering-Plough and Centocor warn that, since infliximab's launch in 1998, six cases of hepatosplenic T-cell lymphoma have been reported in patients with Crohn's disease treated with infliximab.

Five of these cases were in patients aged 12 to 19 years; all patients were taking concomitant azathioprine or 6-mercaptopurine. Exposure to infliximab ranged from one infusion to approximately four years of maintenance therapy.

Hepatosplenic T-cell lymphoma is rare and follows an aggressive course, which is usually fatal. The manufacturers say that, although a risk for the development of hepatosplenic T-cell lymphoma in patients treated with infliximab cannot be excluded, the risk benefit ratio remains positive for the approved indications.

It is estimated that approximately 270,000 patients worldwide with Crohn's disease have been exposed to infliximab, 10,000 of these being below 18 years old. In the EU the use of infliximab in patients under 18 years is off-label and its magnitude is unknown.

The cases were identified as part of a US Food and Drug Administration review of infliximab following a licence application for its use in Crohn's disease patients between six and 17 years. The licence was granted in May.

The manufacturers urge health care professionals to report any suspected cases of hepatosplenic T-cell lymphoma. The summary of product characteristics for Remicade will be updated in due course.

Children's persistent coughs may be pertussis

Almost 40 per cent of school children in the UK who visit their GP with a persistent cough have evidence of whooping cough infection, even though they have been immunised, a study has revealed (*BMJ Online First*, 7 July, www.bmj.com).

Researchers tested 172 children aged between five and 16 years with a cough lasting 14 days or longer and found that 64 (37.2 per cent) had evidence of recent pertussis. Over 85 per cent of them had been fully immunised.

The researchers point out that while the study was being conducted the pertussis immunisation policy in the UK was changed. "Whether the most recent alteration to the UK vaccine schedule will shift the age of pertussis infections upwards without fully protecting immunised children against the disease remains to be seen," they say.

The researchers suggest that prescribers should be alert to the possibility of a whooping cough diagnosis. "A secure diagnosis will allow GPs to give parents an indication of the likely length of cough and prevent them prescribing unnecessary drugs for asthma or referring children for further investigations."

In response, the Health Protection Agency said in a statement: "Inactivated vaccines for bacteria usually become less effective over a period of several years. However, the vaccine



Mark Clarke/Science Photo Library

Whooping cough should be considered

protects the very youngest babies very well. It is babies less than six months old who are most at risk from dying from whooping cough and protecting them is the main purpose of the vaccination programme."

□ **Pneumococcal vaccine** Pneumococcal vaccine is to be added to the childhood vaccination programme from September. Children up to the age of two years will be offered the vaccine when they start their routine vaccinations or as part of a catch up campaign.

No strong evidence to favour any one drug for Bell's palsy

No firm conclusions can be drawn about the benefit of any single drug for the treatment of Bell's palsy, the *Drug and Therapeutics Bulletin* says in its July issue (2006;44:52). Trials on the efficacy of drug treatments for the condition have generally been poor. The bulletin says there is weak evidence from one

trial that aciclovir and corticosteroid treatment given together may be beneficial compared with corticosteroid alone, however this combination has not been compared with placebo. The July issue of *DTB* also reviews the treatment of hypothyroidism in pregnant women (*ibid*, p53).

More quit smoking with new drug than bupropion

Varenicline, a partial agonist of the $\alpha 4\beta 2$ nicotinic acetylcholine receptor, is better at helping people to stop smoking and to stay abstinent than both placebo and bupropion SR, according to three studies conducted by the Varenicline Phase 3 Study Group and published in *JAMA* last week.

Two of the studies randomised around 1,000 participants to receive 12 weeks of varenicline 1mg twice daily, placebo or bupropion SR 150mg twice daily, plus weekly brief smoking cessation counselling. Follow-up was for 52 weeks. The third study looked at maintenance therapy by giving 1,210 participants 12 weeks of open-label varenicline plus 12 weeks of additional treatment or placebo.

In one of the comparison trials (*JAMA* 2006;296:56) the short-term and long-term efficacy of varenicline exceeded that of bupropion SR and placebo.

During the last four weeks of treatment, 43.9 per cent of participants in the varenicline group stopped smoking compared with 17.6 per cent in the placebo group (odds ratio 3.85, 95 per cent confidence interval 2.69–5.50; $P < 0.001$) and 29.8 per cent in the bupropion group (OR 1.90, CI 1.38–2.62; $P < 0.001$).

At 24 weeks, 29.7 per cent in the varenicline group were abstinent compared with 13.2 per cent in the placebo group (OR 2.83, CI 1.91–4.19; $P < 0.001$) and 20.2 per cent in the bupropion group (OR 1.69, CI 1.19–2.42; $P = 0.003$). At 52 weeks, the abstinence figures were 23 per cent in the varenicline group compared with 10.3 per cent in

the placebo group (OR 2.66, CI 1.72–4.11; $P < 0.001$) and 14.6 per cent in the bupropion group (OR 1.77, CI 1.19–2.63; $P = 0.004$).

The second comparison trial (*ibid*, p47) yielded similar results except that varenicline was not significantly more efficacious than bupropion at week 52 (21.9 per cent versus 16.1 per cent; $P = 0.057$). The researchers explain that partial agonists can work by two mechanisms. By partially activating the $\alpha 4\beta 2$ nicotinic acetylcholine receptor they can alleviate craving mechanisms and, by occupying part of the receptors and blocking nicotine binding, they can reduce smoking satisfaction. Both of these effects were observed in this trial, they say.

The maintenance study (*ibid*, p64) showed that, during the treatment phase, the abstinence rate was higher in the varenicline group than in the placebo group (70.5 per cent versus 49.6 per cent, OR 2.48, CI 1.95–3.16; $P < 0.001$). This difference was maintained at 52-week follow-up ($P = 0.02$).



Satisfaction reduced with new smoking cessation drug

The most frequent adverse effect to varenicline reported in the three trials was nausea, which occurred in about 30 per cent of participants.

JAMA editorial comment

The authors of an accompanying editorial (*ibid*, p94), believe that the relapse prevention results reported in the maintenance study are probably more optimistic than would occur in the real world since they only take into account people who had quit at 12 weeks. "By eliminating participants who failed to quit smoking in the open label phase, the authors have eliminated one third of individuals for whom this drug does not appear to be effective," they say. "Varenicline definitely is not a panacea for smoking cessation," they add. However, they acknowledge that varenicline represents a third class of drugs, with a different mechanism of action to nicotine replacement therapy and bupropion, and which studies have shown is associated with better quit rates than placebo, and may produce better quit rates than bupropion.

Genetic variation linked with improved response to beta-blocker, say researchers

Researchers have identified a polymorphism that is associated with an improved response to beta-blockers in heart failure.

Stephen Liggett, professor of medicine and physiology at the University of Maryland school of medicine, Baltimore, and colleagues analysed genetic variations associated with the β_1 -adrenergic receptor in a study comparing the investigational beta-blocker bucindolol with placebo in 1,040 heart failure patients.

The researchers found that patients with an arginine variation of the β_1 -adrenergic receptor gene (β_1 -Arg-389) who were treated with active drug had a 38 per cent reduction in mortality compared with arg-389 patients given placebo ($P = 0.03$). Those with glycine at position 389 who were treated with bucindolol had a similar response to those patients given placebo.

"It has been difficult to explain the variability of response to treatment, even among patients with similar ages and other charac-

teristics. This is especially the case with beta-blockers," commented Michael Bristow, a cardiologist at the University of Colorado and one of the study authors. "We hypothesised that the variability in response to beta-blockers was due to important functional genetic variation in the β_1 receptor, and this indeed appears to be the case."

The study is published online this week in *Proceedings of the National Academy of Sciences* (www.pnas.org).

As part of their investigations, the researchers also considered genetic variations and response to bucindolol in black patients compared with white patients. They observed that genetics, not race, determined who benefited from the drug. "We believe it is inappropriate to use a race-based prescribing approach, because within any given ethnic or racial population there is a genetic variability within that group. Therefore, some people will have the response gene and some will not," commented Dr Liggett.

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Newsletters

Newsletters for the Society's special interest groups including the Industrial Pharmacists Group (June) and the Community Pharmacists Group (July).

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Recalls

Product recalls and drug/device alerts from 2001 to date.

www.pjonline.com/recalls

Safety of medicines

"Safety of medicines in practice" is a series in *Hospital Pharmacist*.

www.pjonline.com/safety

Agenda for 2006

This series is intended to make the profession think about its future. Recent articles consider self care, independent pharmacist prescribing and monitoring experiences.

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Abatacept continues to show benefits for rheumatoid arthritis

Positive results continue to emerge for abatacept, the first in a new class of drugs for rheumatoid arthritis that selectively modulates the co-stimulatory signal required for full T-cell activation. A study published in the *Annals of Internal Medicine* last month (2006;144:865) suggests that abatacept reduces disease activity in patients with rheumatoid arthritis who have had an inadequate response to methotrexate.

US researchers randomised 652 patients with active RA despite methotrexate treatment to receive a once-monthly infusion of abatacept 10mg/kg or placebo for one year. The primary outcome measure was a 20 per cent improvement in American College of Rheumatology (ACR) response criteria.

At six months, an ACR20 response was achieved by more patients treated with abatacept than with placebo (67.9 per cent versus 39.7 per cent; $P < 0.001$). At 12 months, ACR20 was achieved by 73.1 per cent of patients in the abatacept group and 39.7 per cent of patients in the placebo group ($P < 0.001$).

Physical function, health-related quality of life and disease activity all improved with abatacept, say the researchers. Abatacept also

slowed progression of structural damage by approximately 50 per cent compared with placebo. However, the incidence of serious infection and infusion reactions was greater in the abatacept group.

The results from a long-term extension arm of the study were presented at the Annual European Congress of Rheumatology in Amsterdam last month. After completing the one-year double-blind phase of the study, 539 patients entered an abatacept extension arm. Data show that two years of abatacept slowed progression of structural damage significantly more than one year of treatment.

□ Abatacept and TNF inhibitor therapy Further data presented at the congress confirmed that the benefits of abatacept, seen at six months in RA patients with an inadequate response to tumour necrosis factor inhibitors (*PJ*, 8 October 2005, p436), are sustained for 18 months. In 317 patients taking conventional disease-modifying antirheumatic drugs but with an inadequate response to TNF inhibitor therapy, continued abatacept therapy resulted in improvements in quality of life scores and physical function, and reductions in disease activity.

Novel targeted approach for prostate cancer tested

A new, targeted RNA therapy has been shown to be effective in a mouse model of prostate cancer, according to research published online in *Nature Biotechnology* on 25 June (www.nature.com).

US researchers combined two approaches to create a hybrid drug — a targeting moiety, called an aptamer, and an RNA-silencing moiety, called a small interfering RNA (siRNA). siRNA molecules can silence gene expression but, until now, researchers have had problems delivering them across cell membranes and targeting them to specific cells.

Aptamer-siRNA chimeric RNAs bind to prostate specific membrane antigen (PSMA), a cell surface receptor overexpressed in prostate cancer cells and in tumour vascular endothelium. They do not bind to or function in cells that do not express PSMA.

The researchers say that aptamer-siRNA chimeric RNAs offer several advantages over proteins: they have low immunogenicity, they can easily be synthesised in large quantities at low cost and they are amenable to a variety of chemical modifications.

The researchers showed that the molecules effectively mediated tumour regression in a mouse model of prostate cancer and they say that, in the future, they may prove to be useful drugs for treating human prostate cancer and other diseases.

POEM

ARBs reduce BP in prehypertensive patients

Clinical question What is the effect of treating prehypertension with an angiotensin-receptor blocker?

Bottom line This study tells us what we already know (that is, that blood pressure medicines reduce blood pressure), but says nothing about what really matters: does intervention in patients with prehypertension improve patient-oriented outcomes? The choice to study such an expensive drug (candesartan) is also disappointing, but not surprising. Given that the number needed to treat (NNT) to prevent one stroke, heart attack, or death in patients with mild hypertension is 140 for five years (www.jr2.ox.ac.uk/bandolier/index.html), it is likely that the actual clinical benefit of treating prehypertension is even smaller.

Synopsis There is an increasing push to define patients as prehypertensive or prediabetic, and patients and prescribers may feel pressure to initiate treatment despite the absence of evidence that active treatment improves outcomes for these "prediseased" patients. In this industry-sponsored study, patients with prehypertension (systolic blood pressure [BP] of between 130 and 139mmHg and diastolic BP of less than 89mmHg or a systolic reading of less than 139mmHg and a diastolic reading of between 85 and 89mmHg) were randomised (allocation concealed) to receive either candesartan 16mg daily or matching placebo. After two years, all patients were given placebo for two years to see if there was any residual effect of treatment. The primary outcome during the four-year study was the incidence of hypertension, defined as an average BP of

140/90mmHg or higher during any three visits, a BP of 160/100mmHg or higher at any one visit, or a BP of 140/90mmHg or higher at the final visit. The average age of patients was 49 years, 59 per cent were men and 82 per cent were white. Analysis was by intention to treat, with the last observation carried forward in the event of missing data.

Not surprisingly, giving BP medication lowers blood pressure: patients receiving candesartan were less likely to have hypertension during the first two active treatment years of the study (13.6 per cent vs 40.4 per cent; $P < 0.001$; NNT 4). After two additional years of treatment with placebo there was still a small residual decrease in the incidence of hypertension requiring treatment (53.2 per cent vs 63 per cent; $P = 0.007$; NNT 10). There was no difference between groups in adverse events, and cardiovascular morbidity or mortality was not reported.

Level of evidence 1b (individual randomised controlled trial with narrow confidence interval)

Reference Julius S, Nesbitt SD, Egan BM, et al, for the Trial of Preventing Hypertension (TROPHY) Study Investigators. Feasibility of treating prehypertension with an angiotensin-receptor blocker. *New England Journal of Medicine* 2006;354:1685–1697.

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