News

ESC issues position paper on new anticoagulants

In a new position paper, the European Society of Cardiology welcomes the new oral anticoagulants for use in atrial fibrillation (*J Am Coll Cardiol* 2012;**59**:1413–25).

Of the three new drugs, the paper appears to particularly highlight apixaban saying it "is currently the best-documented alternative to both warfarin and aspirin for stroke prevention in a broad population with AF".

It adds that "apixaban has been shown to be superior compared with warfarin concerning the reduction of stroke and mortality in combination with a reduction in major bleeding, with a bleeding risk similar to that of low-dose aspirin, and with better tolerability than both these alternatives, albeit with no reduction in ischaemic stroke compared with warfarin".

The paper says dabigatran 150 mg is also a well-documented alternative to warfarin "based on its reduction of haemorrhagic stroke as well as of ischaemic stroke and systemic embolism, with a similar risk of major bleeding and a reduced risk of intracranial bleeding". But it points out that dabigatran is associated with some specific side effects, such as dyspepsia and gastrointestinal bleeding, a trend toward an increased risk of myocardial infarction and needs caution in patients with impaired renal function.

The position paper notes that rivaroxaban has a once daily dose regimen, which may improve compliance, and was "noninferior to warfarin concerning stroke prevention and major bleeding, with a lower risk of intracranial but a higher rate of gastrointestinal bleeding".

Who to treat

On who should receive these new drugs first, the position paper notes that new patients and those not well managed on wafarin are the obvious candidates. It adds that patients already on long-term warfarin with well-controlled INRs and handling the monitoring without problems derive "uncertain overall advantages" from switching to the new oral anticoagulants.

NICE guidance on dabigatran

The National Institute for Health and Clinical Excellence (NICE) has issued its final technology appraisal on dabigatran etexilate (Pradaxa®, Boehringer Ingelheim) recommending it as a possible treatment to prevent stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (AF) and one or more risk factors. NICE said its cost was justified by the benefits it provides compared with other treatments on the NHS.

NICE said the decision about whether to start treatment with dabigatran etexilate should be made after an informed discussion between the clinician and the person about the risks and benefits of dabigatran etexilate compared with warfarin. Full guidance is available at http://guidance.nice.org.uk/TA249

Since the NICE announcement, Boehringer Ingelheim have reduced the NHS cost of dabigatran from £2.52 to £2.20 per day.

ARB number 8 launched in UK

A new angiotensin receptor blocker (ARB), azilsartan medoxomil (Edarbi®, Takeda) has been launched in the UK for the treatment of hypertension. It is the eighth ARB available in the UK and so increases treatment options for hypertensive patients, many of whom are not reaching treatment targets.

Studies involving nearly 6,000 patients with hypertension have shown it lowers blood pressure (BP) significantly more than ramipril, valsartan and olmesartan medoxomil when compared at their maximum doses. It also maintains BP lowering over a 24-hour period.

Data on the new compound were presented by Professor Luis Ruilope, (Hospital 12 de Octubre, Madrid, Spain) at a Takeda-sponsored symposium during the 22nd European Society of Hypertension (ESH) meeting, held in London from 26th–28th April recently.

In one study with ramipril, azilsartan 80 mg once daily provided a 9/6 mmHg greater reduction in clinic BP than ramipril 10 mg once daily, at six months.

A further trial of azilsartan showed that it effectively reduced ambulatory and trough clinic blood pressure versus valsartan 320 mg daily.

The new agent is well tolerated. The more common reported adverse effects with azilsartan are dizziness, diarrhoea, and small, reversible increases in serum creatinine.

Professor Ruilope suggested that the "robust evidence of improved response rates" with azilsartan may be explained by its binding characteristics, showing a high affinity for and slow dissociation from the AT1 receptor. It is a pro-drug, rapidly hydrolysed to its active component, with a half-life of 11 hours.

Because of its selectivity, it may exert a more potent and sustained blood pressure-lowering effect than existing angiotensin receptor blockers, according to some commentators.

The starting dose of azilsartan 40 mg once daily may be increased to 80 mg daily if a patient's blood pressure is not controlled. A lower starting dose (20 mg) should be considered in special groups, such as the very elderly or those with mild to moderate hepatic impairment. Azilsartan's NHS cost is £16.80 for a pack of 28 40 mg tablets.

Ivabradine receives heart failure licence

Ivabradine (Procoralan®, Servier) has been approved for use in heart failure. The licence has been granted for use in patients in New York Heart Association Class II to IV heart failure with systolic dysfunction, in those in sinus rhythm with a heart rate ≥75 bpm. It should be used in combination with standard therapy including beta-blocker therapy or when beta-blocker therapy is contraindicated or not tolerated.

The licence follows the results of the SH/fT trial, involving more than 6,000 people, which demonstrated that patients with chronic systolic heart failure and a heart rate over 70 bpm had an 18% reduction (ARR = 4.2% p<0.0001) in the composite primary end point of cardiovascular death and hospitalisation due to heart failure.

Ivabradine selectively lowers heart rate and the study showed benefits were greater in patients with higher heart rates (>75 bpm). Within the indication, Servier says ivabradine reduced the risk of death from heart failure by 39% (ARR 2.2% p=0.0006), the risk of death from all types of cardiovascular disease by 17% (ARR 2.6% p=0.0166) and the risk of death from all causes by 17% (ARR 2.8% p=0.0109). It also significantly reduced the risk of heart failure patients requiring hospitalisation by 30% (ARR = 6.3% p<0.0001) and improved the quality of life of people living with the disease.

In brief

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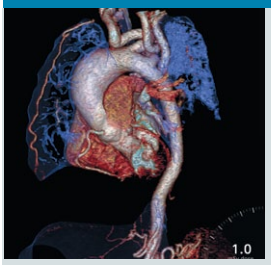

This image of Tetralogy of Fallot has won Carol Young, a radiographer at Great Ormond Street Hospital, London, an award for the best image quality and lowest radiation dose in the Siemens Healthcare International CT Image Contest. She beat 627 other entries from 43 countries

Sitagliptin licence in renal disease

Sitagliptin (Januvia®, MSD) has received a licence in the UK for use in people with type 2 diabetes with moderate to severe renal impairment.

The licence follows data from two clinical studies. In one study comparing sitagliptin (25 mg or 50 mg once daily) with glipizide (2.5 to 20 mg once daily) in patients with type 2 diabetes and moderate to severe renal impairment, the incidence of hypoglycaemia was lower in the sitagliptin group (6.2%) compared to the glipazide group (17.0%). In another study, however, in patients with type 2 diabetes and end stage renal disease on dialysis, results showed no significant difference between patients treated with sitagliptin or glipizide.

First BHF Fellow of the Year

The British Heart Foundation (BHF) has named Dr Nicola Smart the first BHF Fellow of the Year. Working with Dr Paul Riley firstly at the University College London, and now with him at the University of Oxford, Dr Smart's research has made great strides into identifying how cardiomyocytes are regenerated and integrated with heart muscle after injury, leading the way towards future resident-cell-based therapy in ischaemic heart disease.

New editorial board member

We are pleased, to welcome to our editorial board Chris Arden, a Southampton GP with a special interest in Cardiology.

"The last few years have seen exciting developments in both community and hospital based cardiovascular care," he said. "While there are many challenges ahead, in both the organisation and delivery of care, there will be, no doubt, many opportunities to ensure good practice is recognised and shared, with the objective of improving patient experience and outcomes. The BJC will continue to play an important role in informing this process and supporting those with an interest in improving cardiovascular care."