

NORTHERN IRELAND MEDICINES MANAGEMENT NEWSLETTER

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Rosiglitazone: withdrawal from clinical use

Suspension of marketing authorisations for rosiglitazone (Avandia[®] and the combination product with metformin, Avandamet[®]) has been recommended by the European Medicines Agency (EMA), following concerns over excess cardiovascular risks. These medicines will stop being available in Europe within the next few months, assuming the adoption of a legally binding decision by the European Commission.

The UK Commission for Human Medicines (CHM) has advised that:

- Prescribers should put in place a system to ensure that all patients are reviewed and changed to another suitable treatment in line with NICE recommendations (see below for further information).
- Although this change could happen at the next routine appointment, prescribers may wish to see patients sooner rather than later to reduce patient anxiety.
- Patients who are concerned should not stop their treatment but should contact the healthcare professional who is supervising their diabetic treatment.

Action for prescribers

The HSCB Pharmacy and Medicines Management Team advise that, unfortunately, there is no one single alternative to rosiglitazone. A decision should be made for each individual patient depending on their circumstances. However, the following options may be useful:

- Given the recent studies looking at HbA1c targets and the proposed revision to the QOF targets, consider whether the patient actually needs an alternative to rosiglitazone at all. If the patient's HbA1c on rosiglitazone was below 8% and other CV risk factors are well controlled (stop smoking, blood pressure, lipids) and they do not have any evidence of microvascular disease, consider trying without it for a few months and then review the need for an additional intervention.
- It's not advisable to simply switch all patients to pioglitazone. Pioglitazone carries the same risk of heart failure and probably a higher risk of fracture as rosiglitazone. In addition, in the USA the FDA is reviewing data from an ongoing, ten-year epidemiological study designed to evaluate whether or not pioglitazone is associated with an increased risk of bladder cancer.
- Could the patient tolerate an increased dose of metformin? A modified release (m/r) metformin formulation might be better tolerated and is worth considering. The evidence base that the m/r formulation is better tolerated is weak but if it helps an individual patient to tolerate a higher dose of metformin, rather than adding another drug, then it would seem worth a try.
- If rosiglitazone was being used as a second-line treatment with metformin, then consider substituting a sulphonylurea (if appropriate). A sulphonylurea is the recommended usual second line choice according to NICE CG87 (<http://www.nice.org.uk/cg87>).
- NICE CG87 advises that insulin is the usual third-line treatment, after metformin and a sulphonylurea. NICE also advises that this should be human NPH (isophane) insulin with analogues reserved only for certain circumstances.
- If gliptins are considered, remember that they do not have any microvascular or macrovascular outcome data nor do they have long-term safety data.
- Patients could be referred for consideration for exenatide or liraglutide if they fit the NICE criteria. However, neither exenatide nor liraglutide have any microvascular or macrovascular outcome data or any long-term safety data. Patients on exenatide or liraglutide must be reviewed at 6 months.

If you have any questions about this issue, please do not hesitate to contact a member of the HSCB Medicines Management Team.