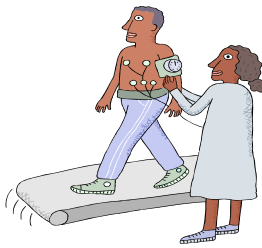




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We are still better at curing than preventing cardiovascular disease!

Cardiovascular disease (CVD) is the commonest cause of death in most European countries; it is also a major cause of disability and incurs huge healthcare costs. Although the availability of pharmacotherapeutic agents has helped to improve patient outcome, in recent years the focus has been on preventive cardiology (via guidelines on lifestyle management) to reduce the modifiable risk factors in patients with existing CVD. The recent **EUROASPIRE III** survey reviewed whether guidelines on lifestyle modification had improved the level of risk factors (*Eur J Cardiocasc Prev Rehabil* 2009; DOI: 10.1097/HJR.0v013e3283294b1d).

Previous surveys (I and II) undertaken in various countries during 1995-6 and 1999-2000 had evaluated the levels of smoking, obesity, hypertension, diabetes mellitus (DM) and raised cholesterol in patients with known CVD. From Sept 2006-April 2007 patients with known CVD for a median of \geq one year (n=8966, 27% females, mean age 61.9 years, from 22 European countries, including Ireland) were interviewed and had blood tests carried out to review whether the prevalence of the above risk factors had changed since the previous studies. Results showed that the percentage of patients who smoked had changed very little from the first study in 1995 (20%) up until 2007 (17%). However, **the percentage of women <50 years who were smokers had increased** during the 12 years. Of interest, the study showed a higher prevalence of smoking in women compared with men in Ireland. Bodyweight was higher in survey III compared with survey I, corresponding to a **35% obesity rate in 2007 vs. 25% rate in 1995. The prevalence of hypertension (>140/90mmHg without DM; >130/80mmHg with DM) was unchanged** across the 3 surveys (58.1%; 58.3%; 56% respectively). The proportion of patients with **raised cholesterol levels showed a significant decline** from survey I (94.5%) to survey II (76.7%) reducing to 51% in III. This was accompanied by a rise in the use of lipid lowering agents. Finally the **levels of DM significantly increased** across the 3 surveys resulting in 25% of patients with diagnosed DM in survey III. In general the use of cardioprotective medication greatly increased during the 12 years' study (overall antiplatelets 91%; β -blockers 80%; ACEIs/ARBs 71%; statins 78%); there was huge variation in usage patterns between the countries. Overall the study showed that large numbers of CVD patients did not achieve the lifestyle, risk factor and therapeutic targets required for CVD prevention. Although cardioprotective drugs are helpful, pharmacotherapy alone is not sufficient. Since it is difficult for adults to change behaviour despite the development of a life-threatening disease such as CVD, the authors suggest that a societal strategy may be necessary.



Obesity reduces life expectancy. Body-mass index (BMI) is thought to be a good measure of general adiposity and raised BMI is a known risk factor for several causes of death including ischaemic heart disease (IHD), stroke and some cancers (e.g. colorectal, kidney, endometrium and post-menopausal breast). However, the precise relationship between BMI and mortality is uncertain; in particular whether pre-existing disease, smoking status, gender or age might influence the relationship. A recent paper evaluated the association between BMI and subsequent causes of death in approximately

900,000 subjects from 57 prospective observational studies (mean age 46 years, 61% male). Baseline information on BMI, blood pressure, total cholesterol, DM and smoking history was available for most subjects. All analyses were adjusted for age, gender and smoking status and the first 5 years of follow-up was excluded to rule out any effect of existing disease. Over a mean follow-up of 6 further years there were 66,500 deaths (mean age 67 years) of which 30,400 were vascular, 22,590 neoplastic, 3,770 respiratory and 9,700 others. **Overall mortality was lowest at about 22.5-25kg/m² in both genders and at all ages, adjusted for smoking status.** Above this range, each 5kg/m² increase in BMI was associated with about 30% higher all-cause mortality. This corresponded to a 40% increased risk for vascular causes (especially IHD), 60-120% for diabetic, renal and hepatic, 10% for neoplastic and 20% for respiratory causes. Below 22.5kg/m² BMI was inversely associated with overall mortality, mainly because of strong inverse associations with respiratory disease and lung cancer (smoking-related). The authors conclude that BMI appears to be an independent, strong predictor of overall mortality.



Where to find information on HPV Vaccines? The NMIC has received several enquiries looking for background scientific information on the use of HPV vaccines. Currently there are 2 vaccines authorised within the European Union. **Gardasil®** is licensed for the prevention of premalignant genital lesions (cervical, vulvar and vaginal), cervical cancer and external genital warts (condyloma acuminata) causally related to HPV types 6, 11, 16 and 18. The licensed indication is based on the demonstration of efficacy of the vaccine in adult females 16-26 years of age and on the demonstration of its immunogenicity in 9 to 15-year old females. **Cervarix®** is licensed for the prevention of premalignant cervical lesions and cervical cancer causally related to HPV types 16 and 18 and its licensed indication is based on the demonstration of efficacy of the vaccine in women aged 15-25 years of age and on the demonstration of its immunogenicity in females aged 10-25 years. The Health Technology Assessment on the **Role of Vaccination against Human Papillomavirus (HPV) in Reducing the Risk of Cervical Cancer in Ireland** is available on the HIQA website at: http://www.hiqa.ie/functions_hta_hpv_overview.asp. In addition, the scientific basis for the licensing of each vaccine is available on the European Medicines Agency website as well as a recent Q & A paper addressing recent adverse events reported with usage. Check out: <http://www.emea.europa.eu/htms/human/epar/c.htm>. Finally, don't forget full prescribing information is also available in the Summary of Product Characteristics for each licensed vaccine at www.medicines.ie; www.imb.ie.



Managing chronic constipation in adults. Chronic constipation in adults is a common and often debilitating problem. A recent review outlined the modern approach to its diagnosis and management (*BMJ 2009; 338: 763-6*). The recent Rome consensus outlined the following criteria for **diagnosis** of chronic constipation. At least two of the following symptoms should be present during at least 25% of defecations over the previous 3 months: straining, lumpy or hard stools, sensation of incomplete evacuation or of anorectal obstruction/blockage and need for manual manoeuvres (digital evacuation or use of pelvic floor muscles). In addition there should be <3 bowel movements/week and loose stools should be rarely present without use of laxatives. There is no evidence to support the routine use of blood tests or abdominal radiography in primary care, apart from full blood count and thyroid function tests if appropriate. **Common causes** include dietary (low fibre, dieting, dementia, depression, anorexia, fluid depletion), metabolic (DM, hypothyroidism, hypercalcaemia, hypokalaemia) iatrogenic (aluminium-containing antacids, iron, anticholinergics, antidepressants, opiates). Painful anorectal conditions such as anal fissure, haemorrhoids, abscess, fistula or neurological conditions such as Parkinson's disease, multiple sclerosis or spinal cord pathology may also result in chronic constipation. The presence of **red flag symptoms** such as bloody or black stools, or the presence of refractory constipation, despite medication, usually indicates the need for specialist referral to rule out sinister causes. **Management:** Most cases of chronic constipation require only simple interventions. **Dietary modification** (increase of fibre), exercise and good hydration seem logical but there is no formal evidence base for these interventions. **Laxatives:** there is good evidence for the use of polyethylene glycol, moderate evidence for lactulose and psyllium (isphagula) husk and few data on the use of other common agents such as senna, bisacodyl and stool softeners. Laxative use should be directed at the specific problem: bulking agents for poor dietary fibre intake; softeners for hard stools and stimulant laxatives for poor colonic motility (e.g. due to opiate use). **Painful anorectal conditions** will also require local application of ointment (e.g. glyceryl trinitrate ointment 0.2-0.4% for anal fissures). In cases of constipation-predominant irritable bowel syndrome, education regarding avoidance of possible triggers is vital as most investigations are normal in this patient group. Biofeedback and targeted surgery are used in specialist settings for chronic constipation resistant to the above measures. [Editor's note: The Rome Foundation (www.romecriteria.org) publishes a series of useful questionnaires and guidelines on the diagnosis and management of a range of functional gastrointestinal disorders]