

Disparity Seen in Decline of Glitazone Use

BY HILLEL KUTTLER

Use of rosiglitazone in physicians' office-based treatment of diabetes patients fell 60%, while pioglitazone use showed just a 9% drop during a 16-month period that included three Food and Drug Administration advisories in 2007 about the drugs' cardiovascular risks.

That gap "is noteworthy," and "con-

siderable evidence supports the greater safety" of pioglitazone over rosiglitazone, Andrew Cohen and his colleagues wrote in an investigation that was published online.

The investigators studied IMS Health's National Disease and Therapeutic Index monthly figures on oral diabetic therapies that were utilized during office treatment visits from January 2003 to June 2009.

Data on the use of the glitazone drug class for diabetic patients aged 35 years and older who did not have type 1 diabetes were analyzed in four time frames: January 2003–January 2005; February 2005–January 2007, a period when safety concerns were first revealed; February 2007–May 2008, when the FDA issued the advisories on cardiovascular risks and 6 months thereafter; and June 2008–June 2009, wrote Mr. Cohen of

the University of Chicago, and his colleagues.

Following the publication of safety concerns that linked glitazone use to serious cardiovascular episodes, but prior to the FDA's advisories, overall glitazone use had begun declining from 34% of type 2 diabetes patients' office treatment visits to 29% (Diabetes Care 2010 Jan. 26 [doi:10.2337/dc09-1834]).

Rosiglitazone use showed a "sharp de-

Obese Women Underscreened For Osteoporosis

WASHINGTON — Obese women are less likely to be screened for osteoporosis than are normal- or overweight women, according to findings from a study of more than 140,000 women included in an integrated health care plan database.

Previous studies have shown mixed results on the disparity in preventive health care for obese patients, compared with normal-weight patients, said Kristi Reynolds, Ph.D., of Kaiser Permanente in Pasadena, Calif., and her colleagues.

"It is largely unknown whether obesity is associated with the quality of care for osteoporosis, which is both preventable and treatable but is often undiagnosed and untreated," the researchers said. Physicians may be less inclined to screen obese women for osteoporosis because body weight is associated with higher bone density, they suggested.

Data from 146,975 health care provider visits in 2007 and 2008 were reviewed.

The average age of the women was 73 years; 35% were normal weight; 35% were overweight; and 19%, 7%, and 4% fell into obesity categories I, II, and III, respectively. Normal weight body mass index (BMI) was defined as 18.5-24.9 kg/m² and overweight as 25-29.9 kg/m²; obese class I was defined as 30-34.9 kg/m², class II as 35-39.9 kg/m², and class III as 40 kg/m² or higher.

About 67% of the women had undergone bone mineral density testing within 4 years of the study, which was the criteria by which participants could be considered "screened." Only 52% of women with a BMI of 40 kg/m² or higher were screened, compared with 68% of each the normal BMI women and of the overweight women, 67% of women with a BMI of 30-34.9 kg/m², and 63% of women with a BMI of 35-39.9 kg/m².

After controlling for age, race, and income, the odds ratio of osteoporosis screening for overweight women was 0.99, while the odds ratios for women in obese classes I, II, and III groups were 0.90, 0.77, and 0.60, respectively. The findings were presented in a poster at the annual meeting of the Obesity Society.

The researchers are employees of Kaiser Permanente. They reported having no financial conflicts of interest.

—Heidi Splete

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Indication

TWYNSTA is indicated for the treatment of hypertension, alone or with other antihypertensive agents. It may also be used as initial therapy in patients who are likely to need multiple drugs to achieve their blood pressure goals. Base the choice of TWYNSTA tablets as initial therapy for hypertension on an assessment of potential benefits and risks including whether the patient is likely to tolerate the starting dose of TWYNSTA tablets. Consider the patient's baseline blood pressure, the target goal, and the incremental likelihood of achieving goal with a combination compared with monotherapy when deciding whether to use TWYNSTA tablets as initial therapy.

Hypotension

Volume depletion and/or salt depletion should be corrected in patients before initiation of therapy or start treatment under close medical supervision with a reduced dose, otherwise symptomatic hypotension may occur. Observe patients with severe aortic stenosis closely for acute hypotension when administering amlodipine.

Hepatic Impairment

In patients with impaired hepatic function, initiate telmisartan at low doses and titrate slowly, or initiate amlodipine at 2.5 mg. The lowest dose of TWYNSTA is 40/5 mg; therefore, initial therapy with TWYNSTA is not recommended in hepatically impaired patients.

Renal Impairment

Monitor carefully in patients with impaired renal function, especially in patients whose renal function may depend on the activity of the renin-angiotensin-aldosterone system (RAAS) (eg, patients with severe congestive heart failure or renal dysfunction); treatment of these patients with ACE inhibitors and ARBs has been associated with oliguria and/or progressive azotemia and, rarely, with acute renal failure and/or death. In patients with unilateral or bilateral renal artery stenosis, increases in serum creatinine or blood urea nitrogen may occur.

Dual RAAS Blockade

When adding an ACE inhibitor to an ARB, monitor renal function closely. Use of telmisartan with ramipril is not recommended.

Other

Uncommonly, increased frequency, duration, and/or severity of angina or acute myocardial infarction have developed in patients treated with calcium channel blockers, particularly patients with severe obstructive coronary artery disease. Closely monitor patients with heart failure.

Adverse Events

In clinical trials, the most commonly reported adverse events with TWYNSTA that were more frequent than with placebo were peripheral edema (4.8% vs 0%), dizziness (3.0% vs 2.2%), clinically meaningful orthostatic hypotension (6.3% vs 4.3%), and back pain (2.2% vs 0%).

Special Populations

In clinical studies, the magnitude of blood pressure lowering with TWYNSTA in black patients approached that observed in non-black patients, but the number of black patients was limited. TWYNSTA is not recommended as initial therapy in patients who are 75 years or older, or who are hepatically impaired. In nursing mothers, nursing or TWYNSTA should be discontinued.

References: 1. Twynsta Pl. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; 2009. 2. Data on file, Study 1235.1, Boehringer Ingelheim Pharmaceuticals, Inc. 3. Chobanian AV, Bakris GL, Black HR, et al. The seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure: the JNC 7 report. *JAMA*. 2003;289:2560-2572.

Please see Brief Summary of Prescribing Information on following pages.

cline” following reports—scientific evidence, the FDA’s advisories, and media coverage—of the cardiovascular risks of glitazone; however, pioglitazone use “did not similarly decline” in light of the FDA’s class-wide advisory, the authors stated.

“Decreases in rosiglitazone and pioglitazone use occurred non-selectively, rather than among those at highest cardiovascular risk,” they said, adding that the changes “are important because glitazones were widely adopted into practice following their market de-

but despite questions regarding their potential safety.”

Although glitazone use showed “rapid

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increases” from the class’s debut—growing at an annual rate of 22%, and peaking at 34% (11.2 million) of all treatment

visits among patients with type 2 diabetes—it decreased at a 29% rate during the FDA advisory period before leveling off to a statistically nonsignificant decline of 2%, the investigators found.

In the latter period, rosiglitazone constituted 23% (1.8 million office visits) and pioglitazone 77% (5.8 million visits) of glitazone use.

The “continuing uncertainty” over the drugs’ cardiovascular risks “suggests the importance of the routine inclusion of cardiovascular end points in

studies that are used to seek FDA approval for diabetes therapies” and “their limited role as monotherapy for diabetes or use in patients at elevated risk of congestive heart failure or ischemic heart disease,” Mr. Cohen and his associates concluded.

The study was funded through a career development award from Robert Wood Johnson Physician Foundation and the Agency for Healthcare Research and Quality to Dr. G. Caleb Alexander, the principal investigator, also of the University of Chicago. No disclosures were reported. ■



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*According to the JNC 7, Stage-1 hypertension is defined as 140-159 mmHg SBP or 90-99 mmHg DBP. Stage-2 hypertension is ≥ 160 mmHg SBP or ≥ 100 mmHg DBP.³

†Standard deviation was 11.9/7.6 mmHg, TWYNSTA 40/5 mg; 13.2/7.9 mmHg, TWYNSTA 40/10 mg; 12.7/8.5 mmHg, TWYNSTA 80/5 mg; 14.2/7.9 mmHg, TWYNSTA 80/10 mg; 16.7/9.4 mmHg, placebo.²

ARB: Angiotensin receptor blocker. CCB: Calcium channel blocker. DBP: Diastolic blood pressure. SBP: Systolic blood pressure. JNC 7: The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.

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