Nearly Half of NSAID Users Require a PPI

BY AMANDA SPAKE
Contributing Writer

Coprescription of a gastroprotective agent with an NSAID is more common than previously reported, especially among patients 55 years of age or older, according to Véronique Rabenda and her associates at the University of Liege (Belgium).

Overall, 47% of patients who received a new prescription for a traditional nonsteroidal anti-inflammatory drug for osteoarthritis, chronic back pain, or other medical conditions also needed a coprescription for a gastroprotective agent, according to a 6-month prospective study.

The investigators looked at 2,197 patients, all of them older than age 35 years, who sought pain management from 66 primary care physicians in Belgium and received a first prescription for a nonspecific NSAID. Patients who had previously used gastroprotective drugs or who had a history of GI symptoms, and those 55 years of age or older, were those most likely to be coprescribed a gastroprotective drug, the investigators reported.

The study shows that "individuals from the age of 55 years may be at significantly higher need for gastroprotective drugs coprescribed," Ms. Rabenda, the lead author of the study, said in an interview. "This pattern of [coprescribing] gastroprotective drugs … may be important information in the context of reimbursement policies," she added.

The 47% rate of coprescription of NSAIDs and gastroprotective drugs in this study is higher than the rate seen in previous studies, according to Ms. Rabenda. She and her coauthors said that their results may mean that physicians need to avail themselves of strategies to reduce the risk of GI bleeding among NSAID users (Osteoarthritis Cartilage 2006;[doi:10.1016/j.joca.2006.01.002]).

Dr. Steven Abramson agreed. "It used to be that when we looked at this issue, about 70% of patients in rheumatology practices had some form of gastroprotection, either a [cyclooxygenase-2] drug or an NSAID, prescribed with a proton pump inhibitor.

"But with the decline in COX-2 prescriptions, there is a real issue of how many people who should receive gastroprotection are actually getting it today," Dr. Abramson, director of rheumatology at the New York University Hospital for Joint Diseases, New York, said in an interview.

He noted that clinicians still face a major issue that the study did not address: "How many people were on low-dose aspirin for heart protection in this study, plus an NSAID, and were they given gastroprotective drugs?"

Ms. Rabenda said that her team has no data on the number of patients who were taking aspirin. But during the 6 months of the study, more than 35% of patients who were not prescribed gastroprotective drugs suffered GI symptoms that apparently went untreated.

Dr. A. Mark Fendrick, professor of internal medicine at the University of Michigan, Ann Arbor, said that he is not surprised that patients taking NSAIDS who need GI protection may not be getting such medications. "A lot of doctors have forgotten why we got into the COX-2s in the first place, and that was because traditional NSAIDs pose serious risks of ulcer and GI damage," he said.

Today, physicians have to evaluate both types of risk when prescribing pain relievers, Dr. Fendrick said. He has put together a chart to aid decision making when prescribing NSAIDs (see box).

He also advocates the development of a tablet that combines both a traditional NSAID for pain with a PPI to protect the GI tract. Pilot studies on a combination drug, developed by Pozen Inc., were announced at the American College of Gastroenterology annual meeting.

Large-scale clinical trials of the combination tablet, known as PN 100, are planned. ■

Clinician's Guide to NSAID Therapy

	No/Low NSAID GI Risk	NSAID GI Risk
Patient not on aspirin prophylaxis	• Prescribe an NSAID.	• Prescribe a coxib or an NSAID and a PPI. • Consider non-NSAID therapy.
Patient on aspirin prophylaxis	• Prescribe an NSAID plus a PPI if GI risk warrants gastroprotection.* • Consider non-NSAID therapy.	• A gastroprotective agent must be added if an NSAID is prescribed.* • Consider non-NSAID therapy.

*Ibuprofen should be used cautiously if individuals are taking aspirin.
Source: Dr. Fendrick, adapted from the American Journal of Managed Care

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Clinical Guidelines For Family Physicians

Restless Legs Syndrome

BY NEIL S. SKOLNIK, M.D., AND MATHEW CLARK, M.D.

Restless legs syndrome (RLS) affects 5%-10% of adults. Historically, the condition has been poorly recognized by physicians, but this is changing. The American Academy of Sleep Medicine (Sleep 2004;27:560-83) and the RLS Foundation (Mayo Clin. Proc. 2004;79:916-22) have recently published guidelines for RLS.

Affected patients typically have trouble with sedentary activities. Insomnia is an especially common and troublesome issue for people with RLS because it may interfere with the initiation or persistence of sleep.

Most cases of RLS are idiopathic, but it is more common in patients with iron deficiency, pregnancy, and end-stage renal disease. It often runs in families.

Guidelines are most useful when they are available at the point of care. A concise yet complete handheld computer version of this guideline is available for download, compliments of Family Practice News, at www.redi-reference.com.

Diagnosis

Diagnosis of RLS is made by history. Patients should experience all four diagnostic criteria: the urge to move, accompanied by dysesthesia; symptoms brought on at rest; symptoms relieved temporarily by movement; and symptoms that become worse in the evening or night.

Polysomnography has no role in diagnosing RLS. Iron status should be assessed via serum ferritin measurement; levels below 50 ng/mL are associated with a greater prevalence of RLS symptoms, even in the absence of anemia.

Management

Not all patients with RLS require treatment with medications. Recommended nonpharmacologic measures include the replacement of iron, if iron deficiency is documented; mental-alerting activities—such as video games or crossword puzzles—at times of boredom or physical inactivity; a trial of abstinence from alcohol, nicotine, and caffeine; and a trial of avoidance of medications with the potential to worsen RLS symptoms. Such medications include antidepressants (except bupropion); neuroleptic agents; dopamine-blocking antiemetics, such as metoclopramide; and sedating antihistamines.

For purposes of management, RLS is divided into intermittent, daily, and refractory types.

Intermittent RLS

Patients with intermittent RLS have symptoms that, when present, are serious enough to require treatment. In addition to nonpharmacologic measures, recommendations include the intermittent use of these medications:

► **One half or one whole tablet of carbidopa/levodopa in the 25/100 formulation, or one tablet of the controlled-release 25/100 formulation.** These can be used at bedtime or for RLS associated with specific activities, such as lengthy rides in a car. They may have unpleasant side effects in some patients.

► **The nonergot dopamine agonists ropinirole or pramipexole.** These medications appear to have fewer troublesome side effects than carbidopa/levodopa. But they take 90-120 minutes to begin working.

► **Low-potency opioids or opioid agonists.** Options include propoxyphene (65-200 mg), codeine (30-60 mg), or tramadol (50-100 mg).

► **Benzodiazepines or benzodiazepine agonists.** Options include temazepam, triazolam, zolpidem, and zaleplon.

Daily RLS

Dopamine agonists are the drugs of choice in these patients. A 0.125-mg dose of pramipexole (Mirapex) is normally taken once daily, 2 hours before major RLS symptoms usually start. This dosage may be increased by 0.125 mg every 2-3 days until symptoms are relieved. Most patients need 0.5 mg or less, although some may require doses up to 2 mg. A daily 0.25-mg tablet of ropinirole (Requip) may be administered 2 hours before symptoms usually appear, and may be increased by 0.25 mg every 2-3 days as needed. Most patients require 2 mg or less, although doses up to 4 mg may be needed.

Gabapentin may be an alternative, particularly in patients with painful symptoms. Treatment is usually given once or twice daily, usually late in the afternoon or before sleep. Dosing may start at 100 mg to 300 mg per dose; mean daily dosages of 1300-1800 mg were used in one trial. Low-potency opioids—such as codeine or propoxyphene—or tramadol may be alternative choices.

Refractory RLS

Patients with refractory RLS symptoms are those whose daily RLS has been treated with a dopamine agonist, but who have experienced one or more of the following: an inadequate initial response despite adequate doses; a response that has become inadequate over time; intolerable adverse effects; or an increasing severity of symptoms that is not controllable with additional earlier doses of the drug. Consider referral to an RLS specialist. The following approaches also might provide relief:

► Change to gabapentin.
► Change to a different dopamine agonist.
► Add gabapentin, a benzodiazepine, or an opioid.
► Change to a high-potency opioid (oxycodone 5-15 mg), hydrocodone (5-15 mg), methadone (5-10 mg), or tramadol (50-100 mg).

Dr. Skolnik is associate director of the family practice residency program at Abington (Pa.) Memorial Hospital and is a coauthor of the "Redi-Reference Clinical Guidelines," a point-of-care reference tool for handheld computers. Dr. Clark is associate director of the family medicine residency program at Abington and has written on restless leg syndrome.