NHS
NPC
National Prescribing Centre
Provided by NICE

MeReC Monthly

No.40 July 2011

MeReC Publications

New meta-analysis on intensive statin therapy supports NICE guidance

A large meta-analysis[1] (>40,000 patients) of randomised controlled trials did not find a statistically significant reduction in all-cause or cardiovascular (CV) mortality with intensive statin therapy, compared with moderate- or low-dose statin therapy. Furthermore, it did not find a linear relationship between LDL-cholesterol lowering and CV risk reduction. In a subgroup of patients with acute coronary syndrome (ACS), there was a significant reduction in all-cause mortality and CV mortality, but not other CV outcomes (e.g. non-fatal myocardial infarction [MI]) with intensive statin therapy compared with lower doses.

Action

Health professionals should continue to follow NICE guidance on lipid modification and use simvastatin ▼* 40mg/day for most people. **NICE lipid guidance explicitly sets no lipid targets that patients are expected to achieve, for either primary or secondary prevention (including those with ACS).** Intensive statin therapy should not be automatic but may be **considered** in certain circumstances, taking into account the patient's informed preference, including the benefits and risks of treatment.

Any possible incremental benefit of using intensive statin therapy over standard doses (e.g. 40mg/day simvastatin) must be considered in the context of an increased risk of adverse events. Health professionals should also note guidance from the MHRA on the use of simvastatin 80mg, which is entirely consistent with NICE guidance.

*Note: The MHRA has advised that the black triangle (▼) refers to intensive monitoring being requested only when simvastatin is used in children and adolescents (10–17 years), in line with the recently licensed paediatric dosing recommendation.

What does this study claim?

This meta-analysis[1] included 10 RCTs (n=41,778). The authors conclude that "the available evidence suggests that intensive statin therapy reduces the risk of non-fatal events and may have a role in reducing mortality". However, in the overall analysis of the results, there was no statistically significant reduction in all-cause mortality (relative risk [RR] 0.92, 95% confidence interval [CI] 0.83 to 1.03, P=0.14) or CV mortality (RR 0.89, 95%CI 0.78 to 1.01, P=0.07), with intensive statin dosing (e.g. atorvastatin 80mg/day) compared to moderate or low dosing (e.g. simvastatin 20mg/day). There was a significant reduction in non-fatal MI, a composite of coronary heart disease (CHD) death and non-fatal MI, and a composite of fatal- and non-fatal stroke (excluding TIA). The authors also did not find an association between LDL cholesterol-lowering and reduction in the risk of CHD death or non-fatal MI.

In a subgroup analysis of three RCTs in patients with ACS, there were significant reductions in all-cause mortality (RR 0.75, 95%CI 0.61 to 0.91, P=0.005) and CV mortality (RR 0.74, 95%CI 0.59 to 0.94, P=0.013, number needed to treat (NNT) over one year 119, 95%CI 63 to 1364) with intensive dosing compared to moderate or low dosing. However, there were no significant benefits in either non-CVD death or non-fatal MI, or in a composite of CHD death or non-fatal MI.

Increased liver enzymes (AST and ALT) were observed more often with intensive dosing, compared with moderate dosing. There was also a significant increase in the risk of creatine kinase above normal levels with intensive dosing, but no significantly increased risk of rhabdomyolysis.

For more information on this study and its limitations see MeReC Rapid Review No. 2835. More information on lipids can be found within the NPC lipids elearning materials.

Reference

1. Mills EJ, et al. Intensive statin therapy compared with moderate dosing for prevention of cardiovascular events: a meta-analysis of >40,000 patients. Eur Heart J 2011 doi10.1093/eurheartj/ehr035

All information was correct at the time of publication (July 2011)

Shared decision-making — ideas and some tools to help

A BMJ editorial[1] and a feature article[2] reporting an expert discussion mark the signing of the Salzburg statement[3] on shared decision-making (See MeReC Rapid Review No. 2865 for more details). Patient decision aids, such as those produced by the NPC, may be helpful in supporting shared decision-making.

Support for professionals and patients

NICE guidance on involving patients in decisions about prescribed medicines and supporting adherence recommends using, among other things, symbols and pictures to make information accessible and understandable. One way of doing this is to use patient decision aids (PDAs). PDAs are described as "evidence-based tools designed to prepare clients to participate in making specific and deliberated choices among healthcare options in ways they prefer. Patient decision aids supplement (rather than replace) clinician's counselling about options".

Many PDAs are intended for use by patients largely away from the consultation, to prepare for the discussion with a health professional. Examples include the three PDAs available on NHS Direct. The PDAs on the NPC website are intended for use by health professionals within the consultation, to support and augment their presentation of the options available to patients, such as the potential risks and benefits of taking a medicine. Since 2007, the NPC has developed a number of PDAs and 30 are currently available to download and use. The single most popular NPC PDA is the one on statins for prevention of cardiovascular disease. NICE highlighted this resource in its guidance on lipid management.

Users are also encouraged to give feedback on their experience of using NPC PDAs via this short anonymous survey, which takes 5-10 minutes to complete. In a recent survey of users, 92% of respondents reported a positive or mixed response to the use of NPC PDAs.

The NPC has also produced a series of short videos showing GPs using some of the most popular NPC PDAs in realistic, unscripted consultations with simulated patients.

References
1. Marshall M and Bibby J. Supporting patients to make the best decisions. BMJ 2011; 342:d2117
2. Gulland A. Welcome to the century of the patient. BMJ 2011;342:d2057
3. Elwyn G. Salzburg statement on shared decision making. BMJ 2011;342:d1745

New legislation — Bribery Act 2010

The Bribery Act 2010[1] came into force on 1st July 2011. This aims to tackle bribery and corruption in both the public and private sector. NHS organisations will need to have "adequate procedures" in place to ensure they comply with the new legislation.

How does this affect NHS organisations?

The Act introduces a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation. It also makes it a criminal offence to give, promise or offer a bribe, and also to request, agree to receive or accept a bribe either in the UK or overseas.

Bribery is generally defined as giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so. For example, this could cover seeking to influence a decision-maker by giving some kind of extra benefit to that decision-maker rather than by what can legitimately be offered as part of a tender process. Reasonable and proportionate hospitality is not prohibited by the Act. The Act's definition of a relevant commercial organisation includes bodies incorporated under the law. Whilst the position for NHS Foundation Trusts is clear, the position for PCTs may be less so. However, all NHS organisations are advised to err on the side of caution and implement adequate procedures.

NHS organisations and staff within the NHS should follow good NHS Business Practice, particularly with regard to procurement and sponsorship. Advice can be found in NHS organisations' policies which will include principles from the Department of Health's standards [HSG (93) 5]. Guidance relating to commercial sponsorship can be found in Commercial Sponsorship Ethical Standards for the NHS. The BMA has recently launched an approach covering ethical procurement.

More information from the Ministry of Justice is available in a quick start guide and guidance on procedures that organisations can put in place to prevent bribery. The NHS Counter Fraud Services team and Local Counter Fraud Specialists may be able to provide further advice and training.

See MeReC Rapid Review No. 3449 for further details.

Reference
1. Ministry of Justice. The Bribery Act 2010

May 2011 Drug Safety Update from MHRA/CHM

The May 2011 edition[1] of Drug Safety Update, published by the MHRA and CHM, gave safety advice on several medicines. In particular it discussed rare but serious hypersensitivity reactions with prasugrel▼ and investigation of the risk of second primary malignancies in clinical trials of lenalidomide▼ for newly diagnosed multiple myeloma. It is important to note that newly diagnosed multiple myeloma is an unlicensed indication of lenalidomide and the MHRA does not recommended it is used for this and other unlicensed indications. In addition, the withdrawal of the antismoking preparation, Nicobrevin, from the UK market because the risks outweigh its benefits is highlighted.

Action

Drug Safety Update is an **essential read** for everyone whose professional practice involves medicines. It is published every month in electronic format only. To subscribe to *Drug Safety Update* please follow this link.

See MeReC Rapid Review No. 3442 for more information.

The June edition of *Drug Safety Update* has also been published and gives updated safety advice on bisphosphonates and Yasmin (see MeReC Rapid Review No. 3920).

Reference

1. MHRA. Drug Safety Update Vol 4, Issue 10, May 2011

The National Prescribing Centre (NPC) is responsible for helping the NHS to optimise its use of medicines. NPC is part of the National Institute for Health and Clinical Excellence (NICE), an independent organisation providing national guidance on promoting good health and preventing and treating ill health.

National Prescribing Centre, Ground Floor, Building 2000, Vortex Court, Enterprise Way, Wavertree Technology Park, Liverpool, L13 1FB
Tel: 0151 295 8691 Fax: 0151 220 4334 www.npc.nhs.uk