

CVD Contraindication Added to Sibutramine

BY ELIZABETH MEHCATIE

The weight-loss drug sibutramine is now contraindicated in people with a history of cardiovascular disease, the Food and Drug Administration announced last month.

The recommendation was based on a review of data indicating an increased risk of myocardial infarction and stroke is associated with the use of the drug in

this population. On the same day, the European Medicines Agency (EMA) announced that after its review of the same data, the EMA's Committee for Medicinal Products for Human Use had recommended that the marketing of sibutramine be suspended in the European Union.

Until now, the sibutramine label had included a warning against its use in patients with cardiovascular disease, but

“based on the serious nature of the review findings, FDA requested and the manufacturer agreed to add a new contraindication,” according to the agency's statement. The FDA is advising that clinicians regularly monitor the blood pressure and heart rate of their patients on sibutramine, and “if sustained increases in blood pressure and/or heart rate are observed, sibutramine should be discontinued.”

The advisory adds that sibutramine should be discontinued in patients who do not lose at least 5% of their baseline body weight within the first 3-6 months of treatment, “as continued treatment is unlikely to be effective and exposes the patient to unnecessary risk.”

Sibutramine, a serotonin-norepinephrine reuptake inhibitor marketed as Meridia by Abbott Laboratories, was approved in 1997.

Concerns about increases in blood pressure and heart rate associated with sibutramine date back to a 1996, when an FDA advisory panel agreed the drug was effective in trials, but voted 5-4 against approval, based largely on concerns over increases in mean blood pressure and heart rate over placebo at all doses studied.

The new contraindication states that sibutramine “is not to be used in patients with a history of cardiovascular disease,” including history of coronary artery disease, history of stroke or transient ischemic attack, history of heart arrhythmias, history of heart failure, history of peripheral arterial disease, and uncontrolled hypertension (such as over 145/90 mm Hg).

The data reviewed by the FDA and EMA were from the Sibutramine Cardiovascular Morbidity/Mortality Outcomes in Overweight or Obese Subjects at Risk of a Cardiovascular Event (SCOUT) study, which compared placebo plus standard care to sibutramine and standard care in about 10,000 overweight or obese patients aged at least 55 years, with a history of cardiovascular disease (CVD) or type 2 diabetes and one additional cardiovascular risk factor.

The study was designed to show that weight loss with sibutramine was more effective in lowering the number of cardiovascular events than with placebo, according to the FDA. But the rate of cardiovascular events among those on sibutramine was 11.4%, compared with 10% in placebo patients, according to preliminary data reported by the FDA in November 2009.

Further review of the data showed that only those participants who had a history of CVD were at an increased risk for cardiovascular events, according to the Jan. 21 statement. Among those with a history of CVD only, and not diabetes, the event rate was 8.3% in those taking placebo, compared with 10.1% in those on sibutramine, a nonsignificant difference.

The difference in cardiovascular event rates between groups did reach statistical significance in patients with both CVD and diabetes, at 11.9% in placebo patients vs. 13.9% in those taking sibutramine. But in patients with diabetes and no history of CVD, the event rates were identical, at 6.5%.

The FDA is planning to hold another advisory panel meeting to discuss the risk-benefit profile of sibutramine and whether any further regulatory action is needed to ensure the safe use of the drug, the statement said. ■

It's never too early to have the “insulin talk”

Some conversations may be hard to initiate. Take the “insulin talk,” for example. According to the American Diabetes Association, insulin is the most effective agent for lowering blood glucose.¹ It works as part of an overall diabetes treatment plan, which may include diet, exercise, and other diabetes medication. Having the “insulin talk” early may help patients accept insulin as a potential treatment option to help them achieve their A1C goals.²

The results of having a positive “insulin talk” can be impactful: in a survey, about 80% of patients with type 2 diabetes on OADs said they'd consider taking insulin if their doctor recommended it.³ So by starting the dialogue now, you can help your patients have a better understanding of insulin as an effective treatment option for lowering blood glucose.

Insulin—a chance for successful glycemic control, not a punishment for failure

Patients may focus on blaming themselves for their uncontrolled blood glucose, but you can help them focus on turning this negative mindset into positive action for managing their disease.² The United Kingdom Prospective Diabetes Study showed that by the time patients with type 2 diabetes are diagnosed, they may already have lost up to 50% of their beta-cell function, and this function may continue to decline.⁴

Because the disease is progressive, many patients with type 2 diabetes may eventually need insulin to achieve or maintain glycemic control.^{2,5} But by the time patients with type 2 diabetes are prescribed insulin, they may have had diabetes for 10 to 15 years and may already have complications due to a prolonged period of uncontrolled blood glucose.⁶ Starting insulin earlier in the disease continuum for appropriate patients can help improve glycemic control. Controlling blood glucose can reduce the risk of diabetes-related complications.^{5,6}

Treatment plans and glycemic targets should be individualized for each patient.

Insulin is indicated to help improve glycemic control in patients with diabetes mellitus.

Important Safety Information About Insulin

Possible side effects may include blood glucose levels that are too low, injection site reactions, and allergic reactions, including itching and rash. Other medications and supplements could change the way insulin works. Glucose monitoring is recommended for patients with diabetes.

THE “INSULIN TALK”

Have the talk early and as needed, to help destigmatize insulin²

- Reassure patients that using insulin doesn't mean failure and that insulin may help replace what the body is no longer adequately making
- Turn the negative mindset of failure into a positive opportunity to take personal control of A1C

Put insulin therapy in context

- Explain the benefits of maintaining blood glucose goals and the risks associated with insulin therapy
- Talk about how insulin may be worth the effort—insulin is an effective treatment option that works as part of an overall treatment plan to lower blood glucose

Identify patients' personal obstacles and help defuse the “scary” factor²

- Today's insulin injections generally cause little discomfort and are administered using small, thin needles^{2,6}
- Insulin pens make insulin more convenient to administer and are discreet²
- Insulin dose may need to be adjusted up or down over the course of treatment depending on how a patient's body responds⁵

INSULIN

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