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What is the role of General Practitioners / Family Physicians in ARB recalls?

Tiago Villanueva
Vice-President, UEMO
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Angiotensin receptor blockers and risk of cancer: cohort study among people receiving antihypertensive drugs in UK General Practice Research Database

BMJ 2012 ; 344 doi: https://doi.org/10.1136/bmj.e2697 (Published 24 April 2012)

Results Follow-up ended a median of 4.6 years after the start of treatment; 20 203 cancers were observed. There was no evidence of any increase in overall risk of cancer among those ever exposed to angiotensin receptor blockers (adjusted hazard ratio 1.03, 95% confidence interval 0.99 to 1.06, P=0.10). For specific cancers, there was some evidence of an increased risk of breast and prostate cancer (1.11, 1.01 to 1.21, P=0.02; and 1.10, 1.00 to 1.20, P=0.04; respectively), which in absolute terms corresponded to an estimated 0.5 and 1.1 extra cases, respectively, per 1000 person years of follow-up among those with the highest baseline risk. Longer duration of treatment did not seem to be associated with higher risk (P>0.15 in each case). There was a decreased risk of lung cancer (0.84, 0.75 to 0.94), but no effect on colon cancer (1.02, 0.91 to 1.16).

What is the role of the GP in ARB prescribing?

- To initiate ARBs for hypertension, heart failure or diabetic nephropathy
- To adjust dosage of ARBs and/or add additional medicines
- To deal with laboratory monitoring
- To deal with adverse drug reactions
- To provide refills
- To maintain prescribing initiated in secondary care

What is the burden of prescribing of ARBs in General Practice?

Table 1 Proportion of patients prescribed each combination of antihypertensive treatment, by class and type of physician.

Initial therapy	Family physicians (n=613)	Other specialists (n=49)	Specialty unknown (n=19)	Total (n=681)
	% (95% CI)			
Lifestyle changes alone	4.7 (3.3-6.7)	0.0 (0.0-8.7)	5.3 (0.0-26.5)	4.4 (3.1-6.2)
ACE inhibitor	31.8 (28.3-35.6)	26.5 (16.1-40.4)	31.6 (15.2-54.2)	31.4 (28.1-35.0)
Thiazide-like diuretic	15.3 (12.7-18.4)	2.0 (0.0-11.7)	10.5 (1.7-32.6)	14.2 (11.8-17.1)
ARB	11.9 (9.6-14.7)	10.2 (4.0-22.2)	15.8 (4.7-38.4)	11.9 (9.7-14.6)
ACE inhibitor and thiazide diuretic	10.3 (8.1-13.0)	6.1 (1.5-17.2)	21.1 (8.0-43.9)	10.3 (8.2-12.8)
ACE inhibitor and CCB	7.7 (5.8-10.1)	12.2 (5.4-24.6)	0.0 (0.0-19.8)	7.8 (6.0-10.1)
ARB and thiazide diuretic	6.2 (4.5-8.4)	12.2 (5.4-24.6)	5.3 (0.0-26.5)	6.6 (5.0-8.7)
Beta-blocker	4.7 (3.3-6.7)	12.2 (5.4-24.6)	5.3 (0.0-26.5)	5.3 (3.8-7.3)
CCB	2.1 (1.2-3.6)	2.0 (0.0-11.7)	0.0 (0.0-19.8)	2.1 (1.2-3.5)
ARB and CCB	2.1 (1.2-3.6)	2.0 (0.0-11.7)	0.0 (0.0-19.8)	2.1 (1.2-3.5)
Other	3.1 (2.0-4.8)	14.3 (6.8-27.0)	5.3 (0.0-26.5)	4.0 (2.7-5.7)

ACE: angiotensin-converting enzyme; ARB: angiotensin receptor blocker; CCB: calcium channel blocker; CI: confidence interval.

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What is the burden of prescribing of ARBs in General Practice?

Table 2 Proportion of patients who were prescribed each class of antihypertensive drugs, by type of physician.

Initial therapy	Family physicians (n=613)	Other specialists (n=49)	Specialty unknown (n=19)	Total (n=681)
	% (95% CI)			
ACE inhibitor	51.2 (47.3-55.2)	51.0 (37.5-64.4)	52.6 (31.7-72.7)	51.3 (47.5-55.0)
Thiazide-like diuretic[a]	32.8 (29.2-36.6)	22.5 (12.9-36.0)	36.8 (19.1-59.1)	32.2 (28.8-35.8)
ARB	20.7 (17.7-24.1)	30.6 (19.4-44.6)	21.1 (8.0-43.9)	21.4 (18.5-24.7)
CCB	13.1 (10.6-16.0)	18.4 (9.8-31.6)	0.0 (0.0-19.8)	13.1 (10.7-15.8)
Beta-blocker	5.9 (4.3-8.0)	20.4 (11.3-33.8)	5.3 (0.0-26.5)	6.9 (5.2-9.1)
Loop diuretic	0.8 (0.3-2.0)	8.2 (2.7-19.7)	0.0 (0.0-19.8)	1.3 (0.1-2.5)
Potassium-sparing diuretic	0.3 (0.0-1.3)	0.0 (0.0-8.7)	0.0 (0.0-19.8)	0.3 (0.0-1.1)
Renin inhibitor	0.0 (0.0-0.8)	0.0 (0.0-8.7)	0.0 (0.0-19.8)	0.0 (0.0-0.7)

ACE: angiotensin-converting enzyme; ARB: angiotensin receptor blocker; CCB: calcium channel blocker; CI: confidence interval.
[a] Includes thiazide diuretics.

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Where do GPs look for information about medicines?

Table 1 a) Percentage of GP respondents rating each information source as 'most important' or 'important' in theory. b) Source from which information about the last new drug prescribed was first derived.

Information source	*a) Important in theory (n = 108)*		*b) Source for last 'new' drug prescribed (n = 90)*
	'Old' drugs	*'New' drugs*	
Drugs and Therapeutics Bulletin	81%	83%	0%
Medical journal articles	63%	77%	9%
Monthly Index of Medical Specialties (MIMS)	59%	60%	0%
British National Formulary (BNF)	58%	56%	0%
Non-sponsored clinical meetings	57%	63%	0%
Primary care colleagues	50%	54%	7%
Consultant/hospital recommendation	36%	69%	36%
Pharmaceutical representatives	26%	62%	42%
Sponsored meetings	21%	44%	1%
Direct mail	15%	35%	1%
Journal advertisements	12%	24%	4%
Others	ni	ni	ni

ni = not indicated. Percentages have been rounded.

Source: Br J Clin Pharmacol. 2001 Feb; 51(2): 184–189.

Perspective

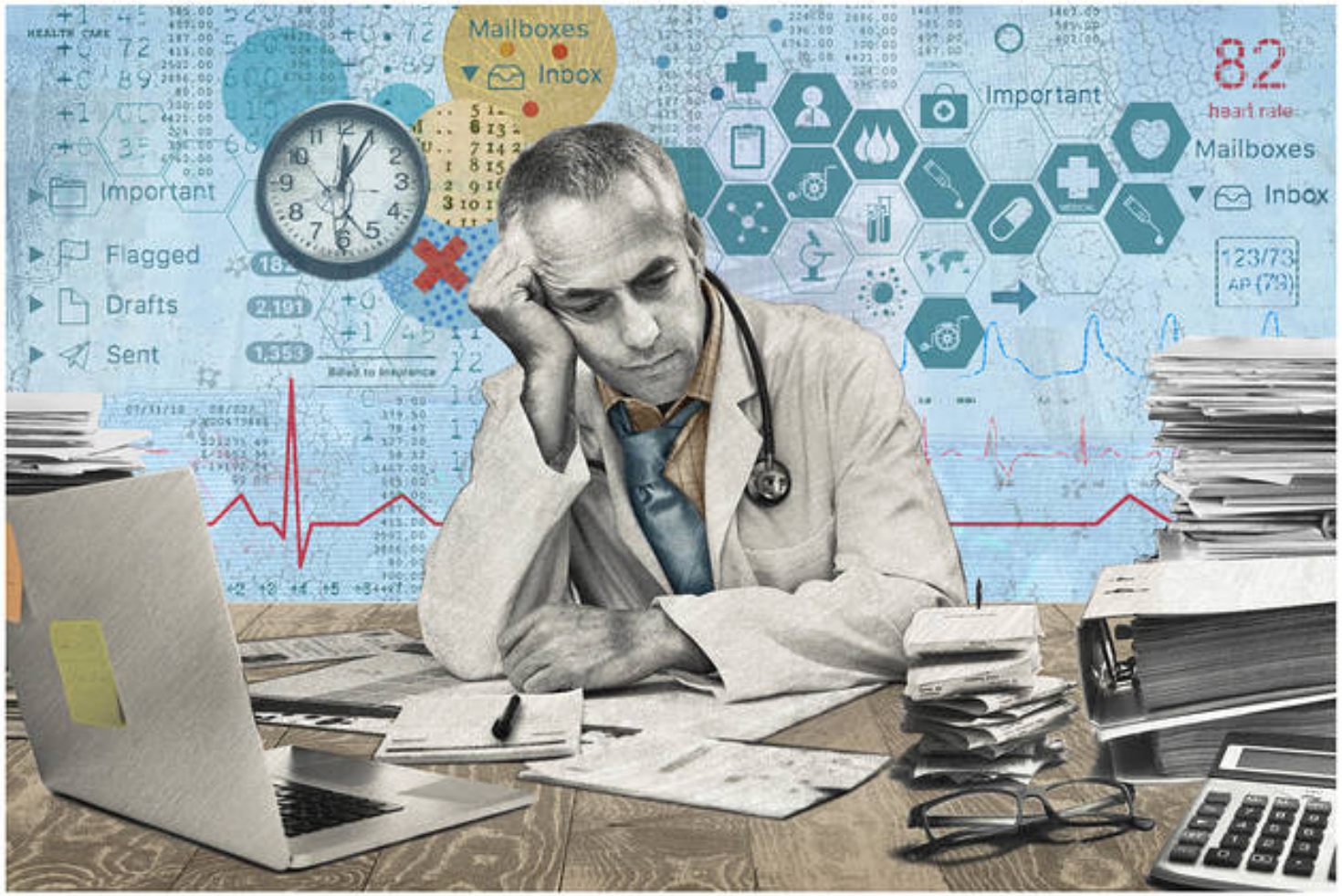
Hypertension Hot Potato — Anatomy of the Angiotensin-Receptor Blocker Recalls

J. Brian Byrd, M.D., M.S.C.I., Glenn M. Chertow, M.D., M.P.H., and Vivek Bhalla, M.D.

"Patients and clinicians may hear about recalls through the news media, social media, pharmacies, health care providers, or friends."

N Engl J Med. 2019 Apr 25;380(17):1589-1591.

Insight regarding the extent of the problem



Source: https://www.wsj.com/articles/hospitals-address-widespread-doctor-burnout-1528542121

Practical challenges in clinical practice

- How to deal with legitimate concerns from patients?
- How to deal with unnecessary concern from patients, who may not be aware of the specific product or manufacturer in question.
- How to deal with patients taking ARBs who may not feel concerned as they are taking ARBs for heart failure or diabetic nephropathy.
- How to select the most appropriate alternative medicines?
- How to deal with increased demand resulting from switching to alternative medicines? What to do when the alternative medicine was later recalled too?

What questions do patients ask GPs?

- Which ARB medicines are affected by recalls?
- What is causing the recalls?
- What is the risk of cancer to patients who have taken the affected medicines?
- What should a patient taking ARBs do now?
- Where can patients find more accurate information?

Conclusions

- The burden of ARB prescribing in general practice is considerable
- GPs may have limited insight regarding the impact of recall on the local community
- ARB recalls may generate increased workload for GPs.
- The problem is not so much lack of information about affected manufacturers and risk of cancer, but timely access to and dissemination of that information in GPs usual sources of information.