Prasugrel and platelet inhibition

One of the primary aims of QJM is to publish topical reviews which are of clinical relevance and provide the best available evidence. In addition, it is important to ensure a considered balance with respect to the views and conclusions presented. There are two review papers this month which fulfil the preceding criteria. While they deal with two quite different clinical subject areas and use diverse approaches in style, they share similarities in that they present an appraisal of therapeutic benefit versus risk but leave the reader to make up his/her own mind. The first review paper by Testa describes the continuing evolution of the thienopyridines in their role of reduction of adverse cardiac events. This group of drugs exert an anti-platelet effect by means of targeting the adenosine diphosphate 2 surface receptor. As a result, they have a potentially beneficial role for patients with stable angina and those recently treated with percutaneous intervention. Ticlopidine was the first drug of this class to be widely used; however concerns regarding its safety were raised with an apparent increased risk of thrombotic thrombocytopenic purpura. Another thienopyridine, clopidogrel was then introduced which was considered to have a more acceptable risk/benefit profile. More recently prasugrel has been approved for use in Europe. This latter agent has been shown to have considerably more anti-platelet activity than clopidogrel alone but this may come with an increased risk of serious bleeding. It is thought that prasugrel has a particular role to play in certain circumstances where prevention of adverse cardiac events is required especially in diabetic patients and where stent thrombosis has occurred despite clopidogrel therapy. Ultimately, it will be left to the discretion of the physician to balance ischaemic protection with risk of haemorrhage. Hopefully this review will be of use in the decision making process.

Inhaled corticosteroids and risk of pneumonia

Inhaled corticosteroids (ICS) represent a useful treatment modality for patients with chronic obstructive airways disease (COPD). However there is a body of opinion that ICS use in this patient group may result in an increased risk of pneumonia. This observation has been supported by evidence from clinical trials and meta-analysis. Singanayagam considers this topic in the second review in this month’s issue. The approach is somewhat novel in that it resembles a grand round debate whereby the argument both for and against the risk of pneumonia with ICS use in COPD is presented for the benefit of the reader. Clinical and in vitro evidence is considered in the argument both for and against the observation. So, what is the considered conclusion? The author argues that those clinical trials that have reported increased risk of pulmonary infection in COPD patients who use inhaled steroids are flawed in their conclusions as none were specifically designed to assess this specific outcome. Furthermore, in vitro studies would suggest that ICS should reduce bacterial invasion of lung tissue. The review would therefore cast some doubt on the alleged association of pneumonia risk and ICS use in COPD. Perhaps the way forward would be a suitably designed prospective trial that would look at this specific association?

Admission to intensive care and oncology patients

Many years ago when the editor was a medical houseman he was called to review a man in his fifties who was becoming increasingly breathless. Examination revealed that the patient was very ill indeed and had worsening respiratory function. In fact, I wondered if he would soon need assisted
ventilation. I rang the medical registrar who reviewed the history with me. Apart from his current pneumonia, the patient also received treatment for a malignancy (I cannot remember specifics). On hearing this, the registrar was of the opinion that admission to intensive care was not appropriate and supportive measures should only be administered. That was over thirty years ago; what has changed in the interim? Certainly there have been impressive advances in oncology care with significant improvements in both short and longer term prognosis for many. However the issue of whether sick patients with a background of malignant disease should by right be admitted to intensive care is still controversial. This is the subject of the paper by Ostermann et al. who undertook a combined retrospective/prospective analysis of outcome for over 100 cancer patients who were admitted to a tertiary intensive care unit (ICU) in London. In brief, the short term outlook was considerably better than that previously reported for oncology patients. It is concluded that mortality following ICU admission was approaching that seen for non-oncology patients. An argument is made that the decision for admission to ICU should be dependent on the severity of acute illness alone. I suspect this paper will produce some degree of debate especially when issues related to the most appropriate use of limited resources are considered.

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