nase levels must be closely monitored. Hypercholesterolaemia, although renal only one that has been shown to prevent cardiovascular complications of hypercholesterolaemia, although renal function and serum creatine phosphokinase levels must be closely monitored.

- **Ivabradine**, an inhibitor of the cardiac I_{1} current, can cause visual disturbances, cardiovascular disorders (including myocardial infarction), potentially severe bradycardia and other cardiac arrhythmias. It has no advantages in angina or heart failure (Prescrire Int n° 88, 110, 118, 135, 165). Established treatments shown to be effective in angina include beta-blockers and the calcium channel blockers amlodipine and verapamil.

There are also better options for heart failure: one is to refrain from adding another drug to an optimised treatment regimen; another is to use a beta-blocker with a proven impact on mortality.

- **Nicorandil**, a vasodilator with solely symptomatic efficacy in the prevention of effort angina, can cause severe mucocutaneous ulceration (Prescrire Int n° 81, 95, 110, 132). A nitrate is a better option to prevent angina attacks.

- **Olmesartan**, an angiotensin II receptor blocker (ARB or sartan) that is no more effective than other ARBs in hypertension, can cause sprue-like enteropathy with chronic diarrhoea (potentially severe) and weight loss, and, possibly, an increased risk of cardiovascular mortality (Prescrire Int n° 148). It is better to choose another of the many available ARBs, such as losartan or valsartan, which do not appear to have these adverse effects.

- **Trimetazidine**, a drug with uncertain properties, is used in angina despite its only modest symptomatic efficacy (shown mainly in stress tests), yet it can cause parkinsonism, hallucinations and thrombocytopenia (Prescrire Int n° 84, 100, 106). It is better to choose better-known treatments for angina, such as certain beta-blockers or the calcium-channel blockers amlodipine and verapamil.

**Dermatology - Allergy**

- **Mequitazine**, a sedating antihista-
mime with antimuscarinic properties, used in allergies, has only modest efficacy but carries a higher risk than other antihistamines of cardiac arrhythmias due to QT prolongation in patients who are slow cytochrome isozyme P450 CYP2D6 metabolisers, and during co-administration of drugs that inhibit this isozyme (Prescrire n° 337). A non-sedating antihistamine without antimuscarinic activity, such as loratadine or cetirizine, is a better option in this situation.

- **Omalizumab** in chronic spontaneous urticaria (see the Pulmonology - ENT section on p. 111) (Prescrire Int n° 161).

- Injectable promethazine, an antihista-
mime used to treat severe urticaria, can cause thrombosis, skin necrosis and gangrene following extravasation or inadvertent injection into an artery (Prescrire n° 327). Injectable dexchlorphrine, which does not appear to carry these risks, is a better option.

- **Topical tacrolimus**, an immunosuppres-
sant used in atopic eczema, can cause skin cancer and lymphoma, yet its efficacy is barely different from that of topical corticosteroids (Prescrire Int n° 101, 110, 131; Rev Prescrire n° 367). Judicu-
sious use of a topical corticosteroid to treat flare-ups is a better option in this situation.

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**Notable changes in the 2016 update:**

citalopram, escitalopram, diclofenac added to the list of drugs to avoid

Three of the drugs that have featured in our list of drugs to avoid since the first version, published in 2013, were withdrawn from the French market in 2015 by the pharmaceutical companies concerned: asenapine for manic episodes; iron dextran for anaemia; and floclofenine for moderate pain.

Pirfenidone: not listed in 2016, but many uncertainties. All the drugs listed in our 2015 review are also included this year, with the exception of pirfenidone, whose harm-benefit balance in idiopathic pulmonary fibrosis has become more uncertain in light of new clinical data. Its clinical evaluation includes some favourable data but still does not show whether or not pirfenidone reduces mortality, even after one year. It is not clear whether the uncertain benefit of this treatment outweighs its harms, which markedly reduce the quality of life of patients whose life expectancy is short, but this does not justify its continued inclusion in our list of drugs to avoid (Prescrire n° 364).

Confirmation: thiocholchicoside, ven-

lafaxine, omalizumab. In 2015, we re-examined certain aspects of the harm-benefit balance of several drugs from our list of drugs to avoid. Our re-evaluation of thiocholchicoside, a drug with a similar chemical structure to colchicine, confirmed its place on the list. Thiocholchicoside has a variety of serious hepatic, pancreatic, muscular, haematological and neurological adverse effects, yet has not been shown to be more effective than placebo in muscle pain (Prescrire Int n° 168).

Re-analysis also confirmed venlafaxine as an antidepressant to be avoided. This antidepressant with serotonergic and noradrenergic activity causes more cardiovascular adverse effects, and is more likely to result in death in the event of overdose, than many other antidepressants over which it has no proven advantages (Rev Prescrire n° 386 and Prescrire Int n° 170). Omalizumab, which is authorised for use in asthma and chronic spontaneous urti-
caria, is no more effective than a cortico-
steroid. In addition to its immunosuppres-
sant effect, the monoclonal antibody causes hypersensitivity reactions and cardiac disorders (Prescrire Int n° 115, 161).

Additions: drugs that are more harmful than similar options. An analysis of the cardiovascular adverse effects of antidepressants revealed that the "selective" seroton reuptake inhibitors (SSRIs) citalo-

pram and escitalopram are no more effective than other SSRIs but cause more cardiac disorders, including dose-dependent prolongation of the QT interval and torsades de pointes (Rev Prescrire n° 386).

Analysis of the cardiovascular adverse effects of nonsteroidal anti-inflammatory drugs (NSAIDs) revealed that diclofenac causes more cardiovascular adverse effects, including myocardial infarction, heart failure and cardiovascular deaths than other NSAIDs, such as ibuprofen (up to a maximum dose of 1200 mg per day) or naproxen, but is no more effective. In the absence of evidence to the contrary, aceclofenac was considered to expose patients to similar risks to diclofenac due to their chemical affiliation, and should therefore also be avoided (Prescrire Int n° 167; Rev Prescrire n° 374).

The efficacy of defibrotide, an antithrom-
bolytic authorised in severe hepatic ven-
occlusive disease following haemopoietic stem cell transplantation, is too uncertain when balanced against its serious adverse effects, in particular haemorrhages (Prescrire Int n° 164).