Dermatology - Allergy

• **Mequitazine**, a sedating antihista-
mine with antimuscarinic properties, used in allergies, has only modest ef-
cacy 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 (*Rev 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) (*Rev Prescrire* n° 161). Injectable **promethazine**, an antihistamine used to treat severe urticaria, can cause thrombosis, skin necrosis and gangrene following extravasation or inadvertent injection into an artery (*Rev Prescrire* n° 327). Injectable **desschlorphentermine**, 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 (*Rev Prescrire* n° 101, 110, 131; *Rev Prescrire* n° 367). Judi-
cious use of a topical corticosteroid to treat flare-ups is a better option in this situation.

Notable changes in the 2016 update: cilofaprol, 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Three of the drugs that have featured in our list of drugs to avoid since the first version, published in 2013, were withdrawn from the French market in 2015 by the pharmaceutical companies concerned: **asenapine** for manic episodes; **iron dextran** for anaemia; and **flotafenine** 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 favour-
able 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 out-
weighs its harms, which markedly reduce the quality of life of patients whose life expectancy is short, but this does not jus-
tify its continued inclusion in our list of drugs to avoid (*Rev Prescrire* n° 364).

**Confirmation**: thiocholicic Acids, 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 **thiocholicic acid**, a drug with a similar chemical structure to colchicine, confirmed its place on the list. Thiocholic acid 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 mus-
cle pain (*Rev Prescrire* n° 168).

Re-analysis also confirmed venlafaxine as an antidepressant to be avoided. This antidepressant with serotoninergic and nor-
adrenergic activity causes more cardiovas-
cular 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 *Rev Prescrire* 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, this monoclonal antibody causes hypersensitivity reactions and cardiac disorders (*Rev Prescrire* n° 115, 161).

Additions: drugs that are more harmful than similar options. An analysis of the cardiac adverse effects of antidepress-
sants revealed that the “selective” sero-
tonin 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 (*Rev Prescrire* n° 374).

The efficacy of **defibrotide**, an anthrom-
botic 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 (*Rev Prescrire* n° 164).

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