Force of habit

The nonsteroidal anti-inflammatory drug (NSAID) *diclofenac* has been marketed in France since 1980. This drug has been considered an appropriate choice among NSAIDs for many years, and its use has become routine.

Over time, as with all drugs, knowledge of *diclofenac*'s adverse effects has broadened. Since 2010, analysis of hundreds of clinical trials and epidemiological studies involving hundreds of thousands of patients has shown an increase in serious cardiovascular adverse effects with *diclofenac*, including myocardial infarction. The frequency of these adverse effects is similar to that seen with cox-2 inhibitors, and greater than that observed with other NSAIDs, such as *naproxen* and *ibuprofen* at moderate doses (see issue 167 pp. 14-16 and this issue p. 298). This excess risk is evident as of the first weeks of treatment, and there is no compensating factor such as greater efficacy or fewer other risks.

This finding is widely known, including by the European Medicines Agency (EMA).

However, as is often the case with the adverse effects of drugs, the translation of new knowledge into healthcare decisions has been slow. Many years have passed, yet *diclofenac* is still authorised for sale, accepted by health insurers and widely used. For example, in 2018, the French national health insurance system reimbursed around 5.5 million boxes of *diclofenac* for oral administration.

Institutional inertia is regularly observed when a commonly used drug turns out to be more dangerous than useful.

Patients, and the professionals who treat them, can bypass this inertia, however. This is even easier when these professionals have, from the start, instilled in their patients the concept that there is no such thing as a "lifelong" treatment, but that the choice of therapy has to be revised in response to changes in key determinants, such as changes in the patient's status and evolving knowledge about the illness as well as its treatment. There is no need to wait, or to be held back by the sluggishness of institutions.

To allow oneself to be guided by habit can be a low-stress option. But where drugs are concerned, habit is often a bad adviser, except for the (good) habit of sharing new knowledge with patients, including knowledge that leads to a decision to avoid using a previously recommended drug. Information on how to do this can be found in *Prescrire*.

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