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Three of the drugs that have featured in our list of drugs to avoid since the first version, published in 2013, were withdrawn from the French market in 2015 by the pharmaceutical companies concerned: asenapine for manic episodes; iron dextran for anaemia; and floctafenine for moderate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 (Rev Prescrire n° 394).

Confirmation: thiocolchicoside, venlafaxine, 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 thiocolchicoside, a drug with a similar chemical structure to colchicine, confirmed its place on the list. Thiocolchicoside 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 nor-adrenergic 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 urticaria, is no more effective than a corticosteroid. In addition to its immunosuppressant effect, this 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 cardiac adverse effects of antidepressants revealed that the “selective” serotonin reuptake inhibitors (SSRIs) citalopram 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 determine optimal treatment regimens, aceclofenac was considered to expose patients to similar risks to diclofenac due to their chemical affiliation, and should therefore also be avoided (Rev Prescrire Int n° 167; Rev Prescrire n° 374).

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

Dermatology - Allergy

• Mequithazine, a sedating antihista-mine 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 (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) (Prescrire Int n° 161).

• Injectable promethazine, an antihis-tamine 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 dexchlorpheniramine, which does not appear to carry these risks, is a better option.

• Topical tacrolimus, an immunosuppressant 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). Judicious use of a topical corticosteroid to treat flare-ups is a better option in this situation.