nase levels must be closely monitored.

function and serum creatine phosphokinase. hypercholesterolaemia, although renal
vent cardiovascular complications of

Only one that has been shown to pre-

The 2016 update: citolopram, 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 with-
drawn from the French market in 2015 by
the pharmaceutical companies concerned:
esenapine 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 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° 394).

Confirmation: thiolochicoside, ven-
lafoxine, 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
thiolochicoside, a drug with a similar
chemical structure to colchicine, confirmed
its place on the list. Thiolochicoside 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 (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 cardiovas-
cular adverse effects, and is more likely
to result in death in the event of overdose,
that 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, this monoclonal antibody
causes hypersensitivity reactions and

Additions: drugs that are more harm-
ful than similar options. An analysis of
the cardiac adverse effects of antidepres-
sants revealed that the “selective” sero-
ton reuptake inhibitors (SSRIs) citol-
opram 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,
acelenofen 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 anthrom-
botic 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).

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Dermatology - Allergy

• Mequitizine, a sedating antihista-
mime with antimuscarnic properties,
used in allergies, has only modest effi-
cacy but carries a higher risk than other
antihistamines of cardiac arrhythmias
due to QT prolongation in patients who
are slow cytochrome isoenzyme P450
CYP2D6 metabolisers, and during
co-administration of drugs that inhibit
this isoenzyme (Rev Prescrire n° 337). A
non-sedating antihistamine without
antimuscarinic activity, such as lorata-
dine 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 dexclor-
pheniramine, which does not appear to
carry these risks, is a better option.

• Topical tacrolimus, an immunosup-
presant 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). Judi-
cious use of a topical corticosteroid to
treat flare-ups is a better option in this
situation.