Nimesulide: patients still exposed to a risk of severe hepatitis

Abstract

Nimesulide, a nonsteroidal anti-inflammatory drug (NSAID), has been on the French market since 1998 (1). It is neither more effective nor better tolerated than many other NSAIDs, and has been shown to cause potentially life-threatening liver damage (1-5).

What is known concerning the hepatic adverse effects of nimesulide in early 2011?

An increasing number of reports of liver damage. Soon after it was first marketed, cases of hepatitis were attributed to nimesulide, including a case of fulminant hepatitis (6). The number of reports increased in all countries where nimesulide was sold (1,3,4).

In 2010, at Prescrire’s request, the European Committee for Human Medicinal Products (CHMP) released a report on the hepatic adverse effects of nimesulide (a)(7).

Between 1985 and 29 February 2008, 574 cases of hepatic disorders associated with nimesulide were reported, including 17 cases necessitating liver transplantation (6 in Italy, 6 in Ireland, 2 in Finland, 2 in France and 1 in Spain) (b)(7-10).

Twice the risk of severe liver damage as with other NSAIDs. A retrospective study of 397 537 Italians using NSAIDs between 1997 and 2001 showed that the risk of severe liver damage was twice as high in patients treated with nimesulide as in those using other NSAIDs: the estimated relative risk adjusted for age and gender was 1.9 (95% confidence interval (CI) 1.1 to 3.8). The difference was statistically significant (c)(11).

A case-control study conducted between 2001 and 2004, but not published until 2010, showed a statistically significant 2.5-fold higher risk of hospitalisation for acute liver damage with nimesulide than with other NSAIDs, with the exception of celecoxib, rofecoxib, diclofenac and ibuprofen (estimated adjusted relative risk 2.63, 95% CI 1.8 to 3.8) (12).

Severe liver damage at standard doses, especially in young women. In 2007, the Italian Medicines Agency released Italian pharmacovigilance data showing that hepatic adverse effects represented 13.8% of reports implicating nimesulide, compared to only 1.4% for ibuprofen and 2.8% for diclofenac (3).

The CHMP report published in 2008 included similar findings. Among the 574 reports implicating nimesulide recorded in the European EudraVigilance pharmacovigilance database, the proportion of hepatic disorders (cholestasis, jaundice, liver failure, and hepatitis) was higher than with cox-2 inhibitors. The report also emphasised that deaths from liver damage were more frequent with nimesulide (7). The CHMP concluded that nimesulide had an unfavourable risk-benefit balance.

67% of cases of liver damage occurred in women and 39% in patients aged between 12 and 55 years (7,13). In 78% of cases, the daily dose taken was that recommended in the summary of product characteristics (SPC) (14).

During the first 15 days of treatment in one-third of cases. In these 574 reports implicating nimesulide, onset of adverse effects occurred within 15 days in 31% of cases, from 16 to 29 days in 14% of cases, and after more than 30 days in 37% of cases; time to onset was not known in 18% of cases (8).

As expected, even though the maximum duration of nimesulide prescription has been limited to 15 days since September 2007, cases of severe hepatitis continue to occur (3,7,13).

Unknown mechanism. The precise mechanism underlying the hepato-...
Adverse Effects

- Toxicity of nimesulide is unclear (15). A hypersensitivity reaction has been suggested (13). In addition, the presence of a nitroaromatic nucleus means that nimesulide is chemically similar to nitrofurantoin and tolcapone, both of which are toxic to the liver (15-18).

In practice: use another NSAID. It is unacceptable to allow nimesulide to remain on the market in 2011: reports of severe liver damage continue to accumulate and many other valid therapeutic options exist. If paracetamol is inadequately ineffective, ibuprofen is the NSAID with the best risk-benefit balance when used at standard doses.

*Review prepared and translated by the Prescrire Editorial Staff (no conflicts of interest)*

Literature search

Our literature search was based on continuous prospective follow-up at the Prescrire library, contents listings of the main international journals, Current Contents-Clinical Medicine, member bulletins of the International Society of Drug Bulletins (ISDB), and systematic consultation of clinical pharmacology textbooks (Martindale The Complete Drug Reference, Stockley’s Drug Interactions). We also accessed Medline (2007-August week 5, 2010), Embase/Excerpts Medica Drugs andPharmacology (2007-2010 3rd quarter), Reaction (2007-September 2010) and The Cochrane Library (Central, DARE, HTA, Nhseed; 2010 issue 6; and CDSR, 2010 issue 3).

- Prescrire Rédaction “Nimesulide et hépatites” Rev Prescrire 2002; 22 (228): 356.
- Prescrire Editorial Staff “Nimesulide and hepatitis” Prescrire Int 2008; 17 (93): 12.
- EMEA - CHMP “Co-rapporteur (Ireland) - Assessment report” EMEA/II/107/871 – Nimesulide-containing medicinal products for systemic use”.
- Prescrire Rédaction “Nimesulide hépatotoxique: la Commission européenne recense les greffes pour hépatite fulminante au lieu de le retirer du marché” and “Point de vue de la Rédaction. Derni-úmeres mortelles” Rev Prescrire 2010; 30 (323): 660-661.

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Azathioprine and mercapto-purine: lymphoma

- Prospective follow-up for a median of 35 months of a French cohort of 19 486 patients with inflammatory bowel disease showed a nearly 4-fold increase in the risk of lymphoma in patients exposed to azathioprine or mercapto-purine (relative risk 3.75; 95% confidence interval 1.59 to 8.85).

- This risk should be taken into account when weighing the likely benefits of these drugs in treatment of patients with severe chronic inflammatory bowel disease no longer responding to first-line treatment.

Azathioprine and its metabolite 6-mercaptopurine are immunosuppressant drugs used to maintain remission in patients with chronic inflammatory bowel disease (ulcerative colitis or Crohn’s disease) (1-3).

Immunosuppressants carry an increased risk of infection and cancer in transplant patients (especially lymphoma) (1).

Prospective follow-up of a French cohort of 19 486 inflammatory bowel disease patients for a median of 35 months has provided informative data on the risk of lymphoma associated with azathioprine and mercapto-purine (4).

Risk of lymphoma about 4 times higher. At enrolment in this study, 5867 patients were taking azathioprine or mercapto-purine, 2809 patients had previously been exposed to these drugs, and 10 810 patients had never taken either drug.

During follow-up, 22 patients developed non-Hodgkin’s lymphoma and 1 patient developed Hodgkin’s disease. Fifteen of these patients were taking azathioprine or mercapto-purine at the time of lymphoma diagnosis, 2 patients had previously taken one of these drugs, and 6 had never taken either drug. The incidence was 0.9 per 1000 among patients taking azathioprine or mercapto-purine versus 0.26 per 1000 among patients never exposed to these drugs.

The risk of developing lymphoma was about 4 times higher in patients exposed to azathioprine or mercapto-purine than in those who had never taken either drug (relative risk 3.75; 95% confidence interval 1.59 to 8.85). After adjustment for variables known to be associated with an increased risk of lymphoma (old age, male sex, longer duration of inflammatory bowel disease), the risk of developing lymphoma was increased by a factor of about 5 in patients exposed to azathioprine or mercapto-purine (relative risk 5.26; 95% confidence interval 2.20 to 12.6).

In practice, Azathioprine and mercapto-purine, like other immunosuppressants, increase the risk of lymphoma. This risk should be taken into account when weighing the harm-benefit balance of these drugs in patients with severe forms of chronic inflammatory bowel disease no longer responding to first-line treatment.

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Selected references from Prescrire’s literature search: