

Nicotinic acid/laropiprant (Tredaptive) now available in New Zealand

Tredaptive, a new product containing extended release nicotinic acid (niacin, vitamin B3) and laropiprant (a prostaglandin inhibitor that minimises flushing), has recently been released onto the New Zealand market. Tredaptive is not funded and is available to patients at a cost of approximately \$100 per month.

Nicotinic acid - place in therapy

Nicotinic acid has long been used to treat lipid disorders, effectively increasing HDL levels and decreasing triglycerides, VLDL and LDL.¹ Used alone or in combination with other lipid lowering agents, it has been shown to prevent the progression of atherosclerosis and significantly reduce cardiovascular events and morbidity.²

Nicotinic acid is particularly useful in combination with statins for those who require additional lipid lowering when statins alone are not adequately controlling dyslipidaemia. It may also be used as monotherapy for people who are intolerant of statins.³

Adverse effects can limit the use of nicotinic acid

Adverse effects, particularly flushing, limit the widespread use of nicotinic acid. Flushing occurs due to cutaneous vasodilatation and is often associated with itching. It is mediated by prostaglandins and occurs in approximately 80% of people taking immediate release preparations of nicotinic acid.¹ Nausea and paraesthesia are other common adverse effects.⁴

Tolerance to nausea and flushing occur rapidly and these symptoms usually stop within two to six weeks. However, if a number of doses are missed in a row (e.g. three or more), these adverse effects may reappear when tablets are started again.⁵ Titrating the dose of nicotinic acid gradually at initiation of treatment can minimise flushing and other adverse effects.⁴ Aspirin (150 mg) taken 30 to 60 minutes before nicotinic acid can also minimise flushing.⁵

Laropiprant minimises flushing

Laropiprant is a highly selective prostaglandin DP1 inhibitor. When used in combination with nicotinic acid, laropiprant has been shown to reduce flushing compared to placebo.⁴ However some flushing may still occur as laropiprant is selective for only one prostaglandin and there are other prostaglandins that may contribute to flushing. Currently, long term safety data for laropiprant is lacking.⁶

References:

1. Rosenson RS. Lipid lowering with drugs other than statins and fibrates. UpToDate 2009. Available from: www.uptodate.com (Accessed October 2009).
2. Kamanna VS, Vo A, Kashyap ML. Nicotinic acid: recent developments. *Curr Opin Cardiol* 2008;23:393-8.
3. British National Formulary 56 ed. London: British Medical Association and the Royal Pharmaceutical Society of Great Britain, 2008.
4. Kamanna VS, Ganji SH, Kashyap ML. The mechanism and mitigation of niacin-induced flushing. *Int J Clin Pract* 2009;63(9):1369-77.
5. Australian Medicines Handbook. Adelaide Australian Medicines Handbook Pty Ltd, 2006.
6. Bays HE, Ballantyne C. What's the deal with niacin development: is laropiprant add-on therapy a winning strategy to beat a straight flush. *Curr Opin Lipidol* 2009;200.

New strength of Fosamax Plus now available

PHARMAC has announced that it has now funded (subject to Special Authority criteria) a new version of Fosamax Plus, containing 70 mg alendronate sodium and 5600 iu cholecalciferol.

This strength of cholecalciferol is now adequate for the treatment of vitamin D deficiency or the prevention of deficiency in high risk groups.

The older version of Fosamax Plus which contained 2800 iu cholecalciferol will be discontinued by the manufacturer and delisted from the pharmaceutical schedule.

In addition, Pharmac has amended the Special Authority criteria for alendronate. A new criterion has been added allowing patients with a ten year risk of hip fracture of

3% or more, calculated using a published risk assessment algorithm e.g. FRAX, to qualify for treatment.

Direct-to-consumer genetic testing becoming more common

Direct-to-consumer genetic testing, offered via the internet by mostly US based companies, is gaining popularity in New Zealand. The implication of this is that GPs are likely to be the first point of contact for people who receive worrying results.

Constant advances in the understanding of disease process is changing the concept of health from being defined as the presence or absence of a disease, to being defined as an increased or decreased statistical probability of future disease.¹ Latest research focuses on identifying genetic markers in complex lifestyle illnesses such as diabetes, cardiovascular disease and obesity. Many companies are “cashing in” on this research. For around \$1000 anyone in New Zealand over the age of 18 years can mail a saliva sample to an overseas company and receive a report detailing their future risk of developing a wide range of conditions including lifestyle illnesses, Alzheimer’s disease and some cancers.

Family history of illness is often why people have this type of testing done, others may simply be curious. The internet based service is very accessible and results are confidential and do not appear on medical records. Critics of direct-to-consumer testing argue that many of the gene associations tested for are unproven and based on immature science with results little more than a genetic horoscope.² The quality of the laboratory and competency of information providers is unknown and there is usually a lack of specialist medical support to help people understand and cope with the results.² There is a concern that medications or alternative health products will be taken by otherwise healthy people that may never develop the disease.¹

As the popularity of genetic testing grows, GPs will increasingly find themselves in the position of having to

understand genetic tests, explain the results to patients and to know how and when to refer patients. In a 2004 survey of GPs in New Zealand, most respondents felt that they had a lack of knowledge about genetic testing, had received little training in this area and were unsure how to contact genetic services locally.³

There are currently no New Zealand guidelines available to assist GPs in understanding genetic testing. Often there is little that can be done to prevent the onset of disease, other than lifestyle measures which should be undertaken regardless of risk factors.

Access to genetic services in New Zealand is limited and restricted to testing for a defined range of conditions with clear genetic inheritance. Northern Regional Genetic services, based in Auckland (with some regional clinics), provides services to people from Gisborne to Northland. Central and Southern Regional Genetics Service has locations in Wellington and Christchurch and provides services to people from Invercargill to New Plymouth.

For further information about referral:



Phone **0800 476 123** (Northern)



Phone **0508 364 436** (Central and Southern)

References:

1. Legge M, Fitzgerald R. Risky knowledges: the sociocultural impacts of personal genetics in a knowledge-driven economy. *N Z Med J* 2007;120(1262).
2. Shelling A. Direct to consumer marketing of genetic testing. Presentation for the National Screening Unit Screening Symposium 2008. Available from: www.nsu.govt.nz/About/2570.asp (accessed October 2009).
3. Morgan S, McLeod D, Kidd A, Langford B. Genetic testing in New Zealand: the role of the general practitioner. *N Z Med J* 2004;117(1206).

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