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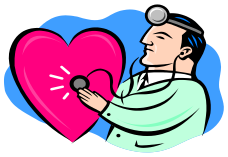

Patients' perceptions of statin usage. It is estimated that 30% of deaths worldwide are caused by cardiovascular disease (CVD). Elevated cholesterol (and in particular low-density lipoprotein, LDL) is a major risk factor for CVD. Use of statins has been shown to result in a 22% relative risk reduction of major CV events with every 1mmol/L reduction in LDL; however their actual benefit/risk and cost-effectiveness depend on the individual's absolute risk of a future CV event. Moreover, evidence shows that many patients for whom statins are indicated and prescribed do not take them; adherence rates at 2 years have been reported to be 57% and 76% for primary and secondary prevention of CVD respectively. A recent systematic review of qualitative studies aimed to identify patients' attitudes towards taking statins (***Brit J Gen Pract 2018; DOI:https//doi.org/10.3399/bjgp18X696365***). A total of 32 studies (n=888 subjects, of whom 41% were taking / had taken statins) from 8 countries were included in the review. Data on attitudes were collected via interviews, focus groups, and open-ended surveys. **Seven themes** were identified: confidence in [CVD] prevention, routinising into daily life, questioning utility, medical distrust, threatening health, signifying sickness, and cost issues. **Attitudes that facilitated acceptance** of and adherence to statin therapy included: awareness of the importance of lowering LDL, confidence in the efficacy of statins to reduce CVD-related events, and the ease of integrating the medication regimen into their daily routine. For these patients, taking statins was viewed as a type of empowerment where patients felt in control of their health condition. **Barriers to acceptance** and adherence included uncertainty about the usefulness of statins, concerns about potential physical and mental side-effects, usage seen as a reminder of a compromised health status, suspicion of their prescriber's motives for use of statins and fear of perpetual dependence. Older patients and those using statins for secondary prevention were particularly positive about statins. For some patients, already taking several medicines, statins were regarded as having a lower priority than e.g. anti-diabetic therapies. Cost was more likely to be raised in US studies, while, the UK studies identified concerns about overprescribing of statins (thought to be due to the publicised NICE guidance for wider prescription of statins). The authors note that these findings are consistent with attitudes reported for other chronic conditions. They recommend that the reasons for prescribing statins and potential patient concerns regarding their usage should be explicitly addressed prior to therapy, and patients should be helped during therapy (e.g. to implement a strategy to "routinise" medication taking and to manage side-effects if they occur) in order to optimise adherence and improve CVD outcomes.

Valproate (Epilim®) toolkit now available online. Valproate is known to have a high teratogenic potential (30-40% risk of developmental disability and a 10% risk of birth defects). The May 2018 edition of the *Therapeutics Today* newsletter provided details of the new contra-indications and strengthened warnings and measures (including the introduction of a pregnancy prevention programme) to further prevent valproate exposure during pregnancy, which were implemented following an EU safety review. (***www.stjames.ie/GPsHealthcareProfessionals/Newsletters/TherapeuticsToday/***)
A toolkit has now been made available by the pharmaceutical company in conjunction with the HPRA; it includes a guide for healthcare professionals, a patient guide for women and girls, a patient alert card and a risk acknowledgement form. The toolkit is available online at: ***www.hpra.ie/valproate***. Paper versions are being distributed by the company to healthcare professionals.

DOACs or warfarin in frail patients*?** Frailty is described as a clinical syndrome associated with a patient's reduced ability to recover from a "stressor" event, because of general physiological decline. It may be associated with ageing, presence of existing morbidity and genetic predisposition. Nonvalvular atrial fibrillation (NVAF) is associated with increasing age and co-morbidity, therefore it is estimated that patients with NVAF may have a 4-fold increased risk of frailty. A recent study compared the efficacy and safety of direct oral anticoagulants (DOACs) with warfarin, in frail patients, using US claims data from 2011 to 2016 (JAHA 2018;doi.org/10.1161/JAHA.118.008643***). Overall results showed levels of risk and benefit, similar to those reported in the DOAC phase III clinical trials. There was no difference in the rates of major bleeding (haemorrhagic stroke, intracranial haemorrhage or gastrointestinal bleeding) for any DOAC (apixaban, dabigatran, rivaroxaban) vs. warfarin at 2 years. Rivaroxaban was associated with reduced stroke or systemic embolism at 2 years vs. warfarin. This study had many limitations (e.g. study based on retrospective review of US data, with different dosage regimens used in US vs. other countries) which may lessen applicability for other countries. However the authors note that although frail patients are less likely to receive anticoagulation compared with non-frail patients, the results of this study show that clinical trial findings appear to be maintained in routine practice in frail patients.

Effectiveness of bath emollients in childhood eczema. Childhood eczema is a common condition that can have a significant impact on children and their families. Emollients are the mainstay of treatment in eczema; these are thought to act as a barrier, by decreasing moisture loss and protecting against skin irritation. While there is evidence for the benefits of regular application of leave-on emollients, there is a lack of evidence for potential additional benefits of bath emollients. A pragmatic open-label randomised controlled trial was undertaken to assess whether bath emollients in addition to standard eczema care was superior when compared with standard eczema care only for childhood eczema (***BMJ 2018;361:k1332***). Participants with childhood eczema (aged 1 to 11 years) were recruited from 96 general practice clinics (GPC) in Wales and England; exclusion criteria included participants with inactive or mild eczema and those who bathed <1/week. Participants in the intervention group (n=264) were prescribed bath additives by their GPC and advised to use them regularly for 12 months; those in the control group (n=218) were not prescribed the bath additives and advised not to use bath additives for 12 months. Both groups were advised to continue with their standard eczema care and given standardised written advice on how to wash, including the use of leave-on emollient as a soap substitute. The primary outcome was eczema severity measured by the **patient oriented eczema measure** (**POEM**), reported by parents/carers weekly over 16 weeks; secondary outcomes included eczema severity measured every 4 weeks for 52 weeks, quality of life and number of eczema exacerbations. **The study found that there was no statistically significant difference in the POEM scores at 16 weeks between the two groups** and there were no significant differences found between the two groups in any of the secondary outcomes. Subgroup analyses suggested the possibility of a small beneficial effect of bath additives in children <5 years, and in those who bathed ≥5 times per week, however the differences were small and considered unlikely to be clinically significant. The authors conclude that the **trial found no evidence of clinical benefit from the inclusion of emollient bath additives into the standard management of childhood eczema**. They advise that further research is needed into optimal regimens for other emollients.

Every effort has been made to ensure that this information is correct and is prepared from the best available resources at our disposal at the time of issue. References are available on request. This ***newsletter is produced by the National Medicines Information Centre, St. James's Hospital (SJH) Dublin 8 and Dept of Therapeutics Trinity College, Trinity Centre, SJH.*** *Tel: Direct Line (01) 473 0589 or 1850 727 727 Email: nmic@stjames.ie*