DC Concept and ACD/DC tool ®

A: ACEI, ARB, Direct Renin Inhibitors
B: BB
C: CCB
D: Diuretic (combo or Aldo antagonist)
DC: Discontinue ineffective drug

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What is DC?

Discontinuing ineffective antihypertensives not being used for their non-antihypertensive pleotropic effects*

Why DC ? part 1

- Effect of antihypertensive medications is largely, if not almost completely is attributable to their ability to lower BP*
- The more BP is lowered the better is the outcome; the reverse should also be true
- The medication that does not lower BP any more than is expected from placebo is not effective (in preventing HTN related complications)

Why DC ? part 2

- Ineffective medications still produce:
  - Medication related cost
  - Additional visits and testing cost
  - Decrease in patient compliance
  - Negative outcomes*
  - Side effects
  - Potential for drug interactions
  - Acceleration of HTN**

History of DC part 1

- When practice of medicine was intuitive and mostly rational, discontinuation of ineffective medications was routine
- After medicine became “evidence based” it was modeled after original double blind trials, where discontinuation of ineffective medicine was not possible due to “blindness” of the provider and the patient

History of DC part 2

- REAL WORLD practice of medicine is NOT BLIND
- Attempts to apply results of the trials to real world frequently lead to keeping patients on ineffective antihypertensive medications

History of DC part 3
Why Did It Take So LONG?

- "Scientist" are not in a position to recommend DC as it has never been formally tested and CAN NOT be tested in BLINDED clinical trial – the only kind of trials "Science" currently accepts for making recommendations
- Regulatory Institutions look at "Scientists"
- Pharma is not interested in DC. Pharma is ANTI DC
- Health insurances adhere to "evidence" and "guidelines" and pay for all of the above

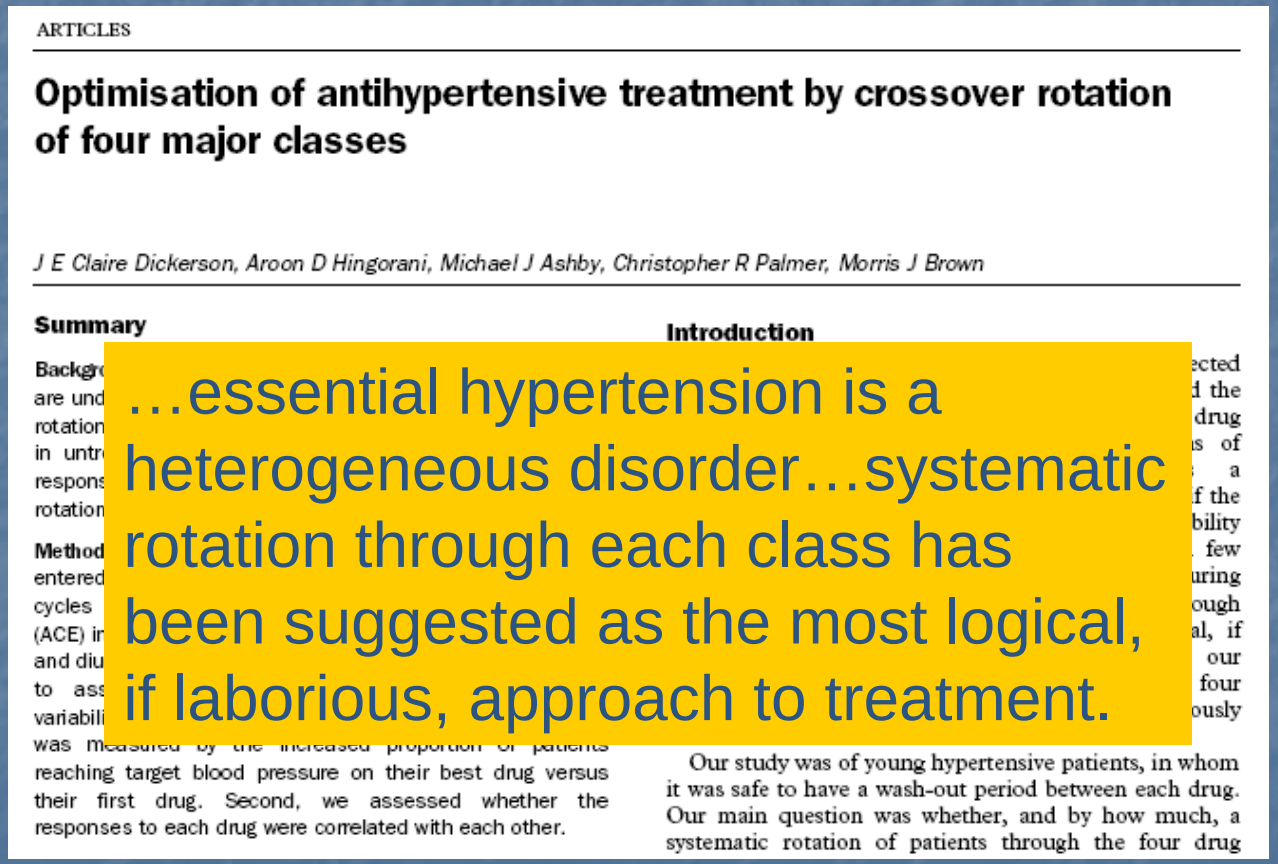
Has Anybody Tried DC Before?

YES!!!

YES!!!

YES!!!

YES!!!



ARTICLES

Optimisation of antihypertensive treatment by crossover rotation of four major classes

J E Claire Dickerson, Aroon D Hingorani, Michael J Ashby, Christopher R Palmer, Morris J Brown

Summary

Introduction

…essential hypertension is a heterogeneous disorder…systematic rotation through each class has been suggested as the most logical, if laborious, approach to treatment.

reaching target blood pressure on their best drug versus their first drug. Second, we assessed whether the responses to each drug were correlated with each other.

Our study was of young hypertensive patients, in whom it was safe to have a wash-out period between each drug. Our main question was whether, and by how much, a systematic rotation of patients through the four drug

Palmer Lancet 1999;353:2008-13

Result of “Rotational Approach”

- Monotherapy target achievement (<140/90) on FIRST drug (in moderate dose) was 39%
- Rotation increased MONOTHERAPY target achievement to 73%
- This means that 34% of patients were spared from extra cost, side effects, etc of LIFELONG combination therapy
- “AB/CD Cambridge rule” was formulated to decrease the number of monotherapy rotations (visits) from 4 to 2
- “ DC ” concept was implied in the overall approach

Palmer Lancet 1999;353:2008-13

“Cambridge AB/CD Rule”

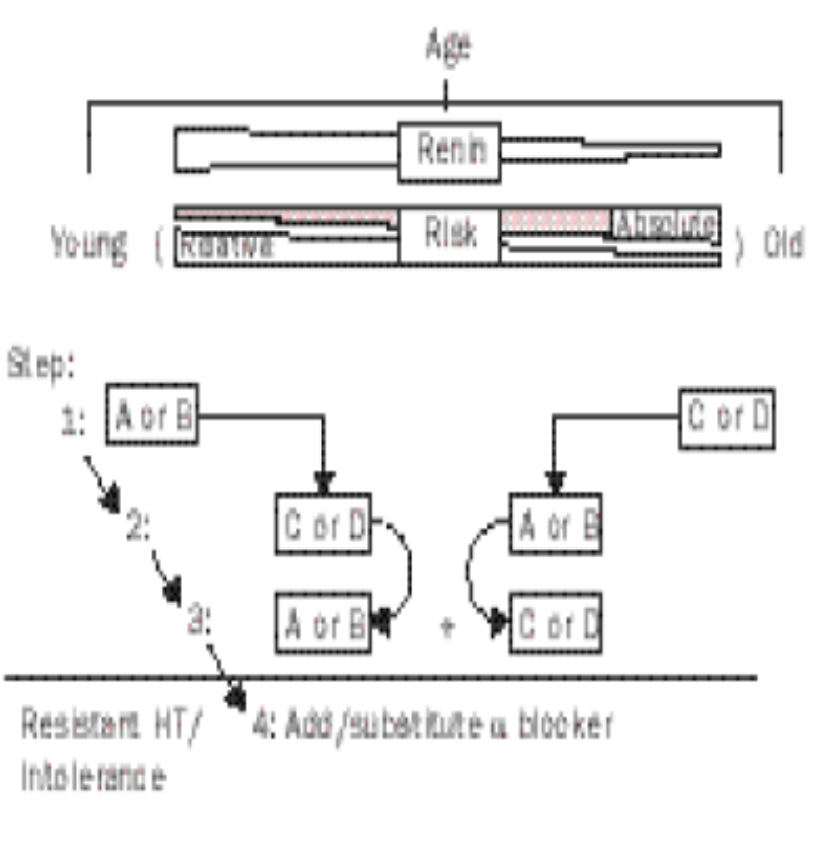


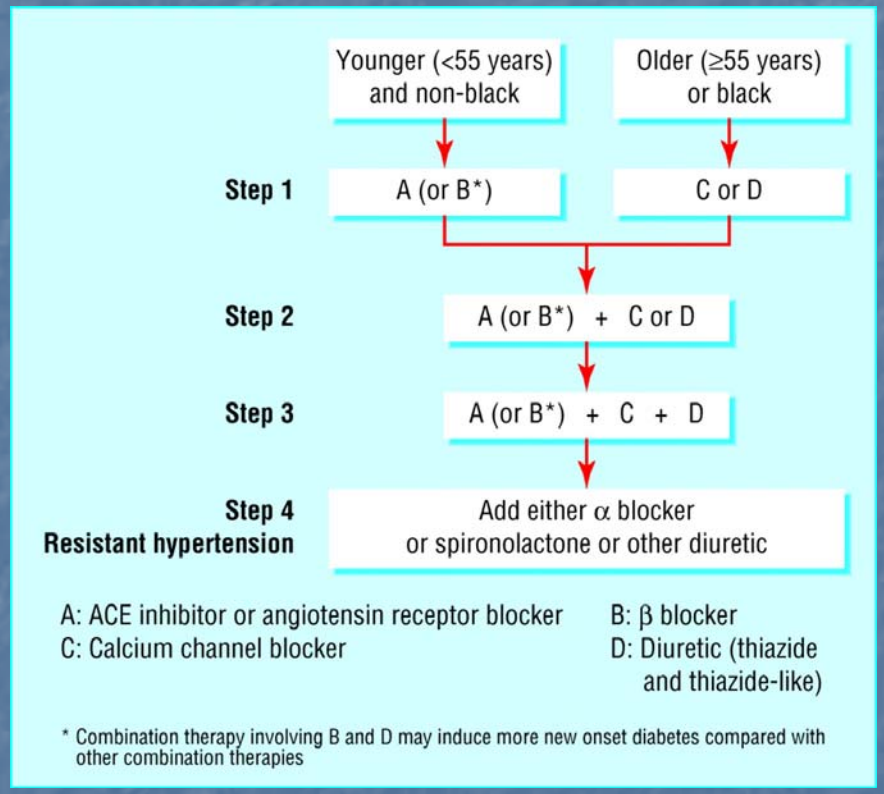
Figure 4: **Cambridge AB/CD rule for optimisation of anti-hypertensive treatment**

The schema represents the recommendations of the text. Steps one and two are monotherapy, with the order influenced by the patient's renin status. This is partly determined by the patient's age and ethnic group, permitting initial selection of treatment without actual renin measurement. Steps three and four are combination treatment. Progress to each step is indicated by failure to meet the treatment target. Decisions to treat hypertension are guided by overall cardiovascular risk assessment. The young are less likely than their peers to reach target age of 70 years (relative risk); older patients have protection factors, but have reduced 5-year survival (absolute risk).[34] A,B,C,D are the initials of the main drug classes, which either block (AB) or stimulate (CD) the renin system.

Palmer Lancet 1999;353:2008-13

What About Guidelines?

- BHS guidelines adapted AB/CD rule with the exception of DC concept in 2004
- And then modified it in 2006 by getting read of the “B”

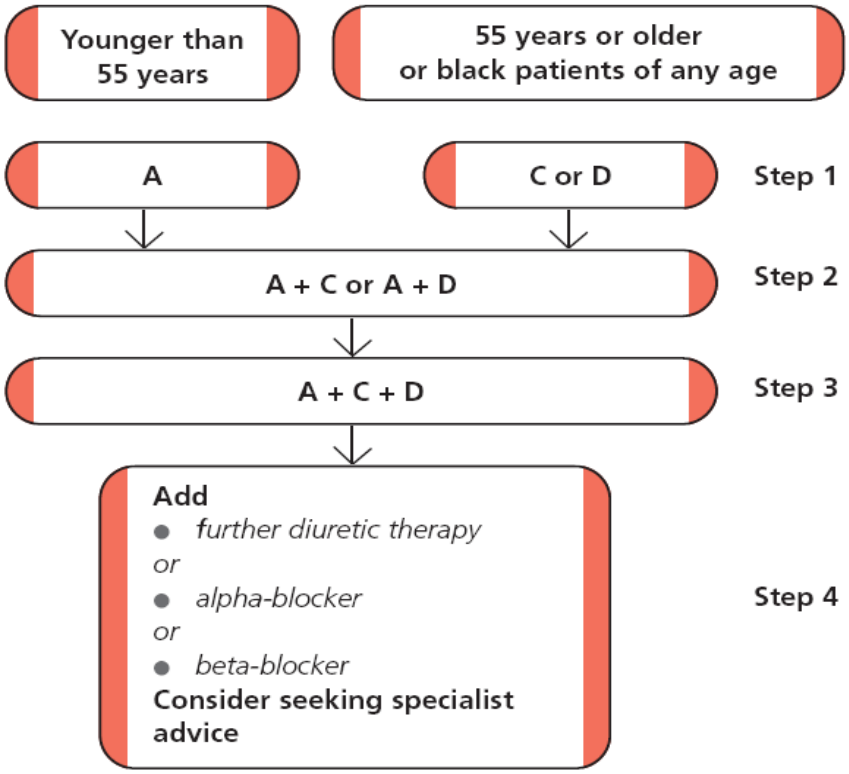


Williams, B. et al. BMJ 2004;328:634-640

Choosing drugs for patients newly diagnosed with hypertension

Abbreviations:
A = ACE inhibitor
(consider angiotensin-II receptor antagonist if ACE intolerant)
C = calcium-channel blocker
D = thiazide-type diuretic

Black patients are those of African or Caribbean descent, and not mixed-race, Asian or Chinese patients



BHS

NHS
National Institute for Health and Clinical Excellence

Somebody HAS to Say IT, at last

"The king has no clothes !!!"

It is time for DC concept to be added to modified AB/CD rule

- Maxim Sungurov, MD
- Dmitri Vasin, MD

Who Will Benefit?

- Patients
- Doctors
- Payers
- Society in general

- Contact us at www.abcdtool.com