this agent. Alternatively, a similar meta-analysis was performed on available data using pioglitazone, and in 19 studies involving over 16,000 patients, pioglitazone reduced cardiovascular outcomes (hazard ratio, 0.82 [CI, 0.7-0.94]).

At this time, a definitive study has not yet been done. It is still reasonable to use TZDs in type 2 diabetic patients in whom other agents, that have a clearer safety record, have failed, such as metformin and sulfonylureas. If a TZD is used, pioglitazone is the preferred agent: It is has a favorable effect on lipids, compared with the slightly unfavorable effects seen with rosiglitazone, and no data suggested that pioglitazone increases cardiovascular risk. On the contrary, pioglitazone may reduce cardiovascular risk.

This study and the others that came after it, highlight the problems with using surrogate markers in diabetes. Improvement in glycemic control, while desirable in theory, may not translate to improved outcomes. Future agents for diabetes should be scrutinized more carefully and not promoted for use without better outcome data over the long-term.

RELATED REFERENCES

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ASTHMA
Randomized comparison of strategies for reducing treatment in mild persistent asthma
The American Lung Association Asthma Clinical Research Centers.

AIM
To determine whether patients with mild persistent asthma that is well controlled by twice-daily inhaled corticosteroids can be managed with simpler treatment regimens.

METHODS
After receiving 6 weeks of twice-daily inhaled fluticasone, 500 patients with well-controlled, mild persistent asthma were randomly assigned to one of three treatment arms: 1) continued twice-daily inhaled fluticasone; 2) once-daily inhaled fluticasone plus salmeterol; or 3) once-daily oral montelukast. Outcomes focused on “treatment failure”, which included such metrics as the need for more intense management and physiologic deterioration and measurement of symptom scores, after 6 months.

RESULTS
Applying this broad definition of treatment failure, the authors found similar failure rates for patients continued on twice-daily inhaled fluticasone or managed with once-daily inhaled fluticasone plus salmeterol (20.2% and 26.4%, respectively) as well as a higher failure rate (30.3%) for patients treated with once-daily oral montelukast (hazard ratio, 1.6 [95% CI, 1.1 to 2.6]). The percentage of days during which patients were symptom free was similar across all three treatment groups (5.8%, 8.27%, and 78.7% [P > 0.10 for all comparisons]). By the end of the study, more patients assigned to receive twice-daily fluticasone (69.7%) or once-daily fluticasone plus salmeterol (78.4%) wished to continue their assigned treatment regimen, compared with those assigned to receive montelukast (56.4%) (P < 0.001).

CONCLUSIONS
Patients with mild persistent asthma that is well controlled with twice-daily fluticasone can be changed to once-daily fluticasone plus salmeterol. Once-daily montelukast proved to be inferior by the outcomes measures in this study but may be an acceptable regimen for some patients.

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