Terazosin reduced BPH symptoms and finasteride did not

Combination therapy was better than zidovudine alone for HIV infection

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The authors compared the efficacy of terazosin, finasteride, or both in men with symptomatic BPH. Inclusion criteria were mean age 65 y, and had symptoms of BPH. Several clinical trials have shown that long-acting α1-adrenergic blockers and finasteride, a 5α-reductase inhibitor, are modestly effective in relieving the symptoms of BPH.

The improvements seen with terazosin alone were modest, but finasteride was no better than placebo in relieving symptoms of increasing urinary-flow rates. With the exception of dizziness and postural hypotension, the side effects of terazosin were mild. Men receiving finasteride were more likely to report sexual dysfunction. A global assessment would have been helpful in showing whether patients considered the benefits of the treatment to outweigh the side effects.

Random variation could easily explain the apparent discrepancy between the lack of benefit from finasteride in this study and the small improvements in symptoms reported in 1992. (Our approach is to start men with symptomatic combination therapy with an α1-blocker. We recommend surgery instead of adding finasteride if our patients' symptoms and residual volumes after voiding are not sufficient to allow single-agent therapy.)

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The results of the Delta study and studies from AIDS Clinical Trials Group (ACTG) 171 (1) and the Community Trials Program for Clinical Research on AIDS (CTRP087) (2) support the superiority of combination therapy over zidovudine and placebo in the treatment of HIV infection. In all 3 studies, the benefits of combination therapy on survival were most obvious in patients without previous zidovudine use. No benefit was seen in patients previously treated. In the Delta study, 99% of patients had previous zidovudine. In all 3 studies, combination therapy improved survival rates and reduced progression to AIDS.

No serious side effects occurred in the Delta study. It and the other studies of combination therapies had a high drug discontinuation rate for nonprotocol reasons.

Eleven antiretroviral agents are now available in the United States and Europe: nucleoside reverse transcriptase inhibitors (zidovudine, ddI, ddC, FTC, d4T), nonnucleoside reverse transcriptase inhibitors (nevirapine, delavirdine, and amprenavir), and protease inhibitors (saquinavir, ritonavir, and indinavir). Clinical studies of combination regimens with protease inhibitors in advanced HIV disease have shown survival benefits and marked improvements in the CD4+ cell count and viral load. The role of these combinations in initial therapy, however, has not been established; resistance may also develop, and important drug interactions complicate their use.

Timming of initiation of therapy, optimal drug combinations, duration of benefit, and when and how to switch drugs need further study. The clinical message, however, is clear: combination regimens can be used to initiate therapy, combination therapy should be started.

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