EDITORIAL

Drugs vs OR time.

Most Canadian urologists are experiencing a resource crunch, which means a constant squeeze on operating time and beds. Ministries of Health (MOHs) face mounting costs, which threaten provincial budgets; hospitals across the country face mounting deficits.

As well, drug costs have risen rapidly. There is a link between these two phenomena.

The COX-2 inhibitor story illustrates the problem. The clinical evidence never suggested that the COX-2s had an advantage with respect to pain relief over earlier NSAIDs. They do have a lower risk of GI side effects, particularly ulceration, in high risk patients. Patients at risk, including those with a history of ulcer disease, on anti-coagulants, or the very elderly, stood to benefit. For others, the benefit was very marginal. In spite of the fact that this class of drugs is among the costliest of oral agents, the COX-2s have become widely employed for the treatment of chronic arthritic and inflammatory conditions. Patients by the millions switched from the previous generation of nonsteroidal anti-inflammatories such as ibuprofen.

Savings from initiating a generic NSAID initially in non-high risk patients would result in enormous savings. The COX-2s cost between a hundred and two hundred dollars a month, and the generic NSAIDs are pennies a day. These are drugs that patients take day in, day out, for years. That kind of change can't be implemented unilaterally: physicians, (and insurers) must convince patients that in their case a brand-new, hundred dollar drug may not be any better than an old, one-dollar drug.

For patients with insurance, there is no advantage in being on a lower cost drug. The absence of appropriate incentives to reduce costs results in a steady increase in drug costs to provincial drug benefit plans, and (in Canada), fewer funds for other resources--like operating rooms, and beds.

Note that spiralling drug costs are not primarily related to an increase in the price of drugs; rather, it is because the volume of costly drugs has increased dramatically.

The withdrawal of Vioxx from the marketplace by Merck has been a sobering experience, Unfortunately, Vioxx turned out, in a prospective randomized trial of colon cancer prevention, to double the risk of myocardial infarction and stroke. This episode deserves reflection, in the context of knee jerk enthusiasm for new drugs.

In an attempt to encourage physicians to reduce drug costs, the proposed Ontario Medical Association-MOH agreement in Ontario will transfer between 50 and 200 million dollars to the pool of physicians income if drug costs can be reduced by $200 million. This raises a serious concern about conflict of interest. Should physicians benefit in a direct monetary fashion by reducing the amount of drugs they prescribe? Will patients lose confidence that their doctor has only their best interests in mind? It is an ethical quagmire.

These issues are relevant to the lead article on the use of bisphosphonates in prostate cancer patients. Zoledronic acid (Zometa), given as a q 3 weekly infusion to patients with hormone refractory bone metastases, reduces the rate of skeletal related events. The studies have not shown an improvement in survival, and the quality of life benefits of the drug must be weighed against the side effects of the drug. The drug (given every 3 months) has also been shown to reverse loss of bone mineral density in men on androgen deprivation therapy (ADT). These findings have resulted in enthusiasm for Zoledronic acid for a narrow indication (asymptomatic hormone refractory bone metastases) and interest in the use of bisphosphonates for men on hormonal therapy for prevention and/or treatment of osteoporosis.

This represents a dilemma for provincial formularies and cancer programs. As a q 3 weekly infusion, the drug costs approximately $675. per month, in addition to nursing costs of administering the infusion. Fortunately, the prevalence of men with asymptomatic hormone refractory bone mets is modest. If the drug becomes widely used for osteoporosis prevention in all men on ADT, these costs will be very substantial.

Assuming these costs are borne by the insurer (provincial drug benefit programs and cancer programs), in an environment of limited resources, what will be sacrificed? The increase in pharmacy expenditure enhances a progressive squeeze on hospital resources.

The next time you complain about lack of OR time, think about drug costs.

Laurence H. Klotz
Editor-in-Chief
Canadian Journal of Urology