Sizing up the costs and availability of drugs

It is ironic that as oncologists struggle to get the time-tested, "good old drugs," which are less expensive but nevertheless essential for many standard chemotherapy regimens, some drug companies are coming out with extremely expensive new drugs. It seems that in their quest for conquering new markets and providing new drug indications, none is looking out for the interests of our patients. Oncologists are the strongest advocates for their patients, and it is important that we are proactive when it comes to addressing the extremely sensitive topic of drug shortages. New, prohibitively expensive drugs might make sense from a dollars-and-cents perspective, but not from the patient or oncologist perspective.

In a Commentary on page 277, my co-editor Debra Patt examines the causes of the drug shortages and offers some possible solutions for alleviating them. She discusses 3 areas of consideration that, if addressed nationally and simultaneously, might effectively stem the shortages: allowing the laws of supply and demand to drive the production and cost of generic drugs; expediting the review process for approving generic drugs; and allowing the use of alternative drugs that are available outside of the United States and are equivalent to those that are in short supply in the US. Dr. Patt also outlines how the US Oncology Network, of which she is a member, has set up a strategy to offset and manage the effects of the shortages. In a related article on page 296, Douglas Hambrick, PharmD, gives some valuable practical insight into how the drug shortages were (or are, in some cases) handled at the large group practice where he is.

Anemia is one of the most common side effects we deal with in patients who are receiving chemotherapy. Management of chemotherapy-induced anemia (CIA) has become particularly vexing after erythropoiesis-stimulating agents were found to increase mortality in patients with head neck cancer and breast cancer. That finding was confirmed in other studies, which led to a change in labeling and a black-box warning for ESAs. Now oncologists are left with the question of how to treat patients with anemia. One easy answer is to use intravenous iron, but many oncologists are reluctant to use parenteral iron because of the associated side effects and questions about efficacy and cost. On page 289, Michael Auerbach and colleagues have written an extensive review of the literature on using IV iron in patients with CIA, and on page 274, David P. Steensma presents a critical commentary on the pros and cons of using IV iron in patients with CIA. The authors strongly suggest that we consider using IV iron in selected patients with CIA. They argue that the treatment is a very safe approach for many patients if it is properly administered.

Also in this issue of COMMUNITY ONCOLOGY is a Community Translations review of carfilzomib, a next-generation proteasome inhibitor that was recently approved for patients with multiple myeloma who have received at least 2 previous therapies. The therapy is an exciting development for patients with multiple myeloma, which has seen more new drugs over the past 5 years than most other diseases. In addition, there is less neuropathy associated with the new therapy compared with other proteasome inhibitors on the market. This is an encouraging development for patients with multiple myeloma, but as you can expect with many new drugs, it comes at a (financial) cost to the patient.

Jame Abraham, MD
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