More Oversight Is Planned

Supplements *from page 1*

ments were regulated under the 1958 food additive amendments to the Federal Food, Drug, and Cosmetic Act.

Dietary supplements fall within the definition of complementary and alternative medicine (CAM). An earlier federal report issued by the Centers for Disease Control and Prevention found that use of CAM is widespread (RHEUMATOLOGY NEWS, Jan. 1, 2009, p. 1). For example, when patients with arthritis become frustrated by lack of pain relief, they often turn to dietary supplements.

The issue of quality control has bothered rheumatologist Dr. Roy Altman for years. Supplements and herbal preparations that are designed to promote joint health and relieve pain are some of the most popular products on the market, grabbing almost as big a market share as do weight-loss products, he said in an interview. "We are looking at probably $40-$60 billion spent on over-the-counter arthritis supplements each year," he said, but he noted that "this is only a fraction of what is spent on prescribed arthritis medications."

Some of these products probably do have a beneficial effect in patients with rheumatic disorders, said Dr. Altman, professor of rheumatology at the University of California, Los Angeles. The problem is identifying which products actually contain what the label promises, and nothing else.

"We and a group of colleagues from Canada once tested 10 different glucosamine products sold [in the United States]. Four of them didn't even have glucosamine in them, and of the remaining six, four had much less than was stated on the product label."

Similar quality control problems led Congress to request the investigation about 18 months ago, said Lisa Shames, the GAO's director of food safety and agriculture issues. "There has been a lot of congressional interest into how FDA was implementing the requirements [for oversight of dietary supplements and herbal products], especially the requirement for reporting adverse events," she said in an interview.

One of the paper's key findings was that adverse events may be significantly underreported, she said. In December 2007, the FDA began requiring manufacturers of dietary supplements and herbal preparations to report all serious adverse events related to the use of their products. Since then, the FDA "has had a threefold increase in the number of events reported, but the big question is whether [these are] all the events that are happening," Ms. Shames said. From January through October 2008, the FDA received 948 reports of adverse events, compared with 298 over the same time frame in 2007. The FDA "recently estimated that the true number of adverse events could be well over 50,000 each year. We recommended that the FDA require reporting of all adverse events, regardless of their severity."

'I try to steer my patients toward brands I have personally investigated ... but there are no databases that contain this information, so people can't make informed choices.'

The report also called on the FDA to require more information from manufacturers about the ingredients in their products. "There is a real lack of information that FDA needs," Ms. Shames said. "Herbal products are not registered by the companies that produce them, and companies are not required to tell FDA what product they sell."

Also, under current law, manufacturers are the ones to decide whether an ingredient is "generally recognized as safe," and thus exempt from the laws that govern pharmaceutical products, she said.

The report asked that the FDA take part in this responsibility by clarifying the evidence needed to document an ingredient's safety and the methodology necessary to establish that safety.

The agency should also increase its efforts to educate the public about the safety of supplements, the report concluded. "People think all these products are safe and approved by the FDA, and of course, this isn't the case," Ms. Shames said.

The report didn't even touch on manufacturing issues, which are controlled by a set of laws that until recently left manufacturing oversight to the companies, with little government regulation.

In 2007, the FDA finalized its Good Manufacturing Practice regulations, which will require quality control measures for all domestic manufacturers and for foreign manufacturers that distribute in the United States. But the law is being phased in by company size, with the smallest companies having until June 2010 to come into full compliance.

Dr. Altman noted that the medical literature contains virtually no data on which brands of supplements or herbal preparations most closely resemble their labeling.

Nor is country of manufacture a good guideline, Dr. Altman said. "You might think you are better off buying something that was made in [the United States, but in reality a lot of those [products] are manufactured in China and then repackaged" here.

The unreliability of labeling puts both physicians and patients in a bind, he said. "It does present a real dilemma, because even if it's a safe product, like glucosamine, and you'd like to use it, there is no way of really knowing for certain what you're getting. I try to steer my patients toward brands I have personally investigated and feel comfortable with, but there are no databases that contain this information, so people can't make informed choices."

Dr. David Riley is another physician who relies on personal experience to guide his selection of such products. Founder of the Integrative Medicine Institute in Santa Fe, N.M., Dr. Riley treats his patients with a combination of allopathic and complementary and alternative medicine, including herbs and supplements.

He said the supplement and herbal manufacturing practices in the United States compare poorly to those in Western Europe. "There, most of the products are regulated by a process that looks much more like the way we... regulate pharmaceuticals," he said in an interview. "I would say that most of the products produced in the United States and Europe meet more stringent manufacturing requirements than those produced in China and India."

Products imported from those countries have a history of poor quality. In fact, a recent study rather spectacularly showcased the problem, Dr. Riley said. Researchers obtained 190 Ayurvedic medicines from Internet sources and determined their components by x-ray fluorescence spectroscopy.

They found that 20% contained some level of toxic metal (lead, mercury, or arsenic). U.S.-manufactured products were just as likely to be contaminated as were those made in India (22% vs. 19%).

The FDA's Good Manufacturing Practices had no impact on the likelihood of contamination. Among companies manufacturing the metal-containing products, 75% claimed that they adhered to the GMP regulations (JAMA 2008; 300:915-23). ■

Many With Controlled RA Experience Uncontrolled Pain

BY MICHELE G. SULLIVAN

Despite having clinically well-controlled disease, more than half of patients with rheumatoid arthritis experience moderate to severe pain, and few take the medications necessary to control it, according to findings from a prospective study.

Patients and rheumatologists share the responsibility for inadequate pain control, Dr. Mary-Ann Fitzcharles and her colleagues found. Rheumatologists tend to ignore pain in favor of focusing on disease control, whereas patients are afraid of the very medications that could help control pain, wrote Dr. Fitzcharles of McGill University in Montreal (J. Pain 2009;10:300-5).

"Both rheumatologists and patients have been lulled into believing that pain is simply part of the condition," she said in an interview. "Our patients were very, very cautious about pain medication. They are scared of addiction, they dislike taking even more pills, and they worry about drug interactions, side effects and masking disease progression. We rheumatologists, on the other hand, focus predominately on trying to control the inflammatory disease. We have not appreciated the importance of pain to these patients and simply don't ask about it."

The study comprised 60 patients with RA who attended a specialist rheumatology practice. In all, 54 (90%) were women; their mean age was 57 years. They had been diagnosed with RA for a mean of 14 years. Most (54, or 90%) were taking disease-modifying antirheumatic drugs.

Patients were asked to complete several questionnaires about pain and quality of life, including the Health Assessment Questionnaire, McGill Pain Questionnaire, and a visual analogue pain scale. They were also asked about potential barriers to pain control with medications.

A seeming contradiction appeared almost immediately, Dr. Fitzcharles said. Despite 39 (65%) patients' reporting satisfaction with their pain control, 28 (47%) reported a desire for additional pain relief, and 32 (53%) reported experiencing moderate to severe pain. Almost half (45%) reported that the pain caused them moderate to severe distress, and the same percentage reported that pain exerted a moderate to severe interference with their daily activities.

"This was most striking," she said. "They believed their pain was controlled, yet they were still having pain. And most were not using any modality to reduce the pain. Of the 60 patients, only 4 were taking anything stronger than acetaminophen."

Patients expressed a high degree of concern about taking pain medications. More than half of the group (55%) expressed at least three barriers to taking such drugs. In all, 48 (80%) were worried about the side effects; 38 (63%) disliked taking even more pills; 34 (57%) worried about drug interactions; 21 (35%) had concerns about addiction; and 16 (27%) thought that controlling pain might mask disease progression. The higher the patient's pain level, the more barriers the patient felt toward controlling that pain.

Patients with RA seem to believe that pain is "an inevitable symptom," and that little can be done about it, Dr. Fitzcharles and her colleagues wrote. "The importance of pain may also take second place to other effects of RA, including the impact on self-esteem due to deformity, the systemic effects of fatigue and depression, and functional limitations due to mechanical joint dysfunction."

Rheumatologists can—and should—do more to investigate pain in their RA patients, the authors said. Patients should be specifically questioned about pain, because many will not volunteer this information. It's also a good idea to explore their worries about pain medication. ■