

# The Prudent Prescriber

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Pharm Reps ≠ Rational Prescribing

(PR)



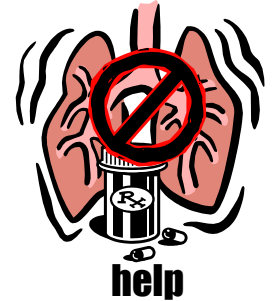
(RP)

December 2005

## Blues Muse

- Depression is common in primary care and the great majority of patients with clinical depression are cared for by primary care physicians.
- Unfortunately, most clinical research in depression is done in secondary settings (i.e. psychiatric).
- Two recent meta-analyses seem useful: Avroll et.al. in Annals Family Medicine Sept/Oct 2005, and Hansen et.al. Ann. Int. Med. 2005; 143:415-26.
- The first study explored the question: "Do SSRIs or tricyclics (TCA) work better than placebo in a primary care setting?" There were 10 studies comparing TCAs with placebo, three in which SSRIs were compared with placebo and two with both compared with placebo. Half of the studies were of poor quality and most were of short duration, typically 6 – 8 weeks.
- Results:
  - ☆ 56%–60% of the patients responded to active treatment compared with 42%–47% for placebo.
  - ☆ The number needed to treat for TCAs was ~4 and SSRIs, 6.
  - ☆ Dropout rates for SSRIs were 5.4% and 12% for TCAs.
- The second study asked the question, "Which of the non-tricyclic antidepressants is safer and more effective?" The 46 studies, 85% of which were sponsored by a pharmaceutical company, were of variable quality.
- Results:
  - ☆ 20 of the 22 effectiveness trials found no difference between the two antidepressants they compared.
  - ☆ Neither faster onset of action nor improved quality of life were identified consistently for any one specific drug.
  - ☆ The overall incidence of adverse effects and discontinuation rates were similar among the antidepressants, although specific adverse effects were significantly different.
  - ☆ Nausea and vomiting rates were higher for venlafaxine (Effexor) than other antidepressants. Sexual side effects (continued)

**Antibiotics do NOT**

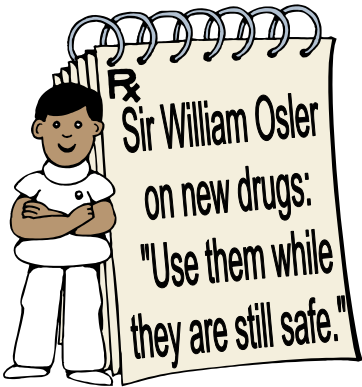


**help acute bronchitis**

**β-blockers in post-MI save lives**

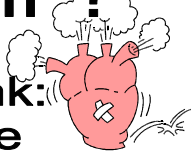


**Pill splitters save big**



## CHF?

Think:  
**Ace**  
**Aldactone**  
**B-blocker**  
**Dig**  
**Diuretic**



Avoid these expensive "me-too" drugs:

- Zegerid
- Z-Max
- Ambien CR
- Clarinox
- Paxil CR
- Xopenex



**Treat diabetics BP to 130/80**



**now available**  
 on the  
**Generic Marquee**

**Allegra** → fexofenadine  
**Oxycontin** → oxycodone SR  
**Zithromax** → azithromycin  
**Biaxin** → clarithromycin

were less frequent with bupropion (Wellbutrin) than with sertraline (Zoloft) and fluoxetine (Prozac).

#### My Take:

- Antidepressants work but they are probably not as effective (70%–80%) as I've preached to my patients in the past.
- Publication bias further overstates antidepressant effectiveness.
- There is a lack of evidence to suggest that any one of the newer drugs is more effective than any other new drug or the older TCAs.
- Although current guidelines often exclude TCAs, the evidence supports their efficacy and safety in selected patients. I continue to prescribe trazadone firstline in depressed patients where sleep disturbance is a major issue. One memorable patient with priapism is the only significant ill effect that remains firm in my memory.
- Recognize that with efficacy rates around 60%, we will frequently need to switch antidepressants at least once.
- It remains prudent to select antidepressants based on the differences in side effects and cost.

DRUG	TYPICAL COST PER MONTH FOR INSURED PATIENTS (Including \$3 dispensing fee)
Trazadone, 300mg/day	\$14 generic
Fluoxetine, (Prozac) 20mg/day	\$7 generic
Citalopram, (Celexa) 20mg/day	\$10 generic
Paroxetine, (Paxil) 20mg/day	\$31 generic
Effexor, 75mg BID	\$109
Effexor XR, 150mg/day	\$95
Bupropion SR, 150mg BID	\$71 generic
Wellbutrin SR, 150mg/day**	\$170 AWP, \$71 MAC
Lexapro, 10mg/day	\$75
Zoloft, 50mg/day	\$90

\*\* If a generic is available, then MAC pricing is typically applied toward the multi-source branded drug; most pharmacies will not usually allow this type of claim to adjudicate.

### What's New Generically, A to Z?

- **A**mbien (Zolpidem) is scheduled to go generic in mid 2006 (currently \$3 each for 5mg tabs).
- **C**iprofloxacin has been generic for some time, but the AWP cost has remained pricey (>\$5/500mg tablet). This drug was recent MAC'd (Maximum Allowable Cost) at 32 cents for a 500mg size tablet. MAC is a prescription drug cost management program that sets a cap on the reimbursement to a pharmacy for a particular drug regardless of whether it is brand or generic. In other words, a MAC is the highest unit price that will be paid for a particular drug or its equivalent. It is designed to contain costs through incentivizing dispensing of lowest priced drugs and to control future cost increases. This process is used extensively by private insurers and is used by some state-run health programs. Unfortunately, uninsured cash-paying patients will continue to shell out the higher AWP for ciprofloxacin.
- **Z**ithromax went generic the end of last month. The cost of azithromycin (\$50 for six 250mg tabs) will not fall much initially, but insured patients will often have a smaller co-pay. In spite of the FDA's approval, azithromycin is a poor choice for acute sinusitis.



### What Works?

#### Saw Palmetto for BPH

Debruyne et.al. in both Prog. Urology June 2004 and Eur. Urol. 2002; 41:497-507 reports a new study plus a previous meta-analysis that show that saw palmetto plant extracts are as effective as or more effective than finasteride (Proscar) and tamsulosin (Flomax) in decreasing both irritative and obstructive urinary symptoms in BPH. In a subset of a previous BPH study, 124 men with severe symptoms (International Prostate Symptom Score {IPSS} >19) were randomized to saw palmetto or tamsulosin. At 12 months, the total IPSS decreased by 7.8 with saw palmetto (320mg/day) and 5.8 with tamsulosin (0.5mg/day).

**NOTE:** The reader is responsible for using professional judgment to confirm and interpret the data presented here before prescribing.