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Published in:
B M J: British Medical Journal

DOI:
10.1136/bmj.323.7310.427

2001

Citation for published version (APA):

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Prescriptions with potential drug interactions dispensed at Swedish pharmacies in January 1999: cross sectional study

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BMJ 2001;323:427-428
doi:10.1136/bmj.323.7310.427

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integrated specialist teams can deliver high quality care to these vulnerable patients.

We would like to thank Mental Health Foundation and Research Into Ageing, who funded studies from which some of the data were acquired.

Contributors: All authors helped to formulate the study design, coordinate the collection of data, and write the paper. CB undertook the data evaluation and will act as guarantor.

Funding: None.

Competing interests: None declared.


(accepted 6 April 2001)
Dextropropoxyphene was dispensed with alprazolam on 261 occasions (this combination may cause serious clinical consequences (type D) was low (1.4%), serious and potentially fatal drug interactions—for example, NSAID and warfarin, potassium sparing diuretics, dextropropoxyphene and carbamazepine, and cisapride and fluconazole—were detected. The risk of interactions with cisapride was known in 1996, and cisapride, which is still available in Sweden, is being withdrawn in many countries.

Prescribing pairs of drugs with potential interactions increases the risk of, but need not lead to, an adverse reaction. Many drug interactions are susceptible to control by dose adjustment; moreover, some are beneficial and are exploited in therapeutics.

National monitoring of potential drug interactions in Sweden is feasible. Differences in healthcare systems need to be considered when extrapolating the results of this study to other countries.

Comment

Although the percentage of potential drug interactions that may have serious clinical consequences (type D) was low (1.4%), serious and potentially fatal drug interactions—for example, NSAID and warfarin, potassium sparing diuretics, dextropropoxyphene and carbamazepine, and cisapride and fluconazole—were detected. The risk of interactions with cisapride was known in 1996, and cisapride, which is still available in Sweden, is being withdrawn in many countries.

Prescribing pairs of drugs with potential interactions increases the risk of, but need not lead to, an adverse reaction. Many drug interactions are susceptible to control by dose adjustment; moreover, some are beneficial and are exploited in therapeutics.

National monitoring of potential drug interactions in Sweden is feasible. Differences in healthcare systems need to be considered when extrapolating the results of this study to other countries.

Rationing in the NHS: audit of outcome and acceptance of restriction criteria for minor operations

Ciaran P O’Boyle, Richard P Cole

General practitioners’ referrals for skin lesion excisions constitute a large proportion of cases seen at plastic surgery clinics. Escalating rates of skin cancer have increased the numbers of urgent referrals due to suspicious looking skin lesions. As a result, patients with clinically benign lesions spend long periods on waiting lists, exceeding the waiting times agreed in negotiated contracts.

In March 1999, a total of 666 patients had been waiting over one year for minor plastic surgery at Salisbury District Hospital. In response, Salisbury Health Care NHS Trust and Wiltshire Health Authority proposed a new system of contract exclusions, whereby only patients with lesions that suggested malignancy or that were disfiguring or potentially disfiguring would be seen. The health authority and the trust assumed that excluded patients would not be seen or treated elsewhere. The consultant plastic surgeons reviewed the referral letters for patients who were not given an operation and returned the letters with explanatory notes.

This study aimed to assess the acceptability of the new system among patients and general practitioners and to determine the outcome of cases excluded under the new criteria.

Methods and results

Details of all referrals rejected under the new system were collected for six months after its inception on 1 September 1990. In each case, the site and description of the lesion were recorded. General practitioners and patients were contacted by telephone to assess their satisfaction with the system and to determine whether further referrals for excision had been made. The histological diagnosis was obtained for lesions excised after re-referral.

In six months, 112 referrals were rejected. Of these, 99 contactable patients (134 lesions) were followed up; 103 lesions (77%) were in the head and neck. In many referral letters the clinical description was non-specific but did not suggest malignancy or disfigurement.

Nineteen (19%) patients later had their lesions excised; 18 patients had benign pathology, and one had a squamous cell carcinoma. The patient with the carcinoma had been refused treatment solely on the basis of a referral letter—on grounds that this was a cosmetic problem—and afterwards sought a private consultation and subsequent excision.
For those technologies for which cost per QALY or per life year was cited, all received positive recommendations, and all but one (riluzole) had cost per QALY below £30 000. The imposition of restrictions on recommended use generally reduced the cost per QALY. Patients’ values were cited as the reason for recommending riluzole for motor neurone disease (amyotrophic lateral sclerosis form only), despite its relatively high cost per QALY of £34 000–44 000. NICE cited “the severity and relatively short life span of people with ALS and in particular . . . the values which patients place on the extension of tracheotomy free survival time.”

The provisional guidance that recommended against the use of beta interferons and glatiramer for multiple sclerosis cited their relatively high cost per QALY (£40 000 to £90 000 on the most optimistic estimates) and stated that NICE had in mind the cost-effectiveness ratio of technologies it had previously recommended.

The final element of each NICE guidance concerns the costs to the NHS of implementing the guidance (cost impact). Estimates of gross and net costs are provided, the latter taking into account any substitution of old technologies by new ones. The items that led to major increases in net costs were tribavirin and interferon alfa, both prescribed for hepatitis C (£55m in total, possibly spread over several years, and due mainly to a backlog of untreated cases) and glycoprotein Ilb/Ilia inhibitors for acute coronary syndromes (net £30m-31m), with none of the others costing more than £20m. The impact on total net cost was reduced by projected savings for some technologies—notably, restricted use of proton pump inhibitors (projected saving £40m-50m annually). The combined net cost of the 22 judgments was £200m-214m or around 0.5% of annual NHS spending in England and Wales. This provides some indication, on the basis of individual technologies, of the extent to which new health technologies may change net healthcare spending. Increases of this magnitude of the task and the paucity of evidence. By October 2000 NICE had published four guidelines and was working on a further 31, often for the same diseases as those for which guidance on technologies has been issued.

The specification by NICE of conditions for use, which has generally enabled it to keep the cost per QALY below £30 000, could be seen as requiring rationing at a more detailed level, perhaps within some overall guidelines for use. Overall, however, NICE’s guidance recommending use of most technologies appraised will arguably lead to “faster and more uniform access” to these technologies rather than to denial access.

Funding: None.
Competing interests: The author directs a unit that contributes health economics input to NICE assessments. He is also a codirector of the National Horizon Scanning Centre. The views expressed in this article are personal and do not reflect those of any organisation.


Discussion

While NICE has been caricatured under the heading “it’s easier to say yes than no,” it would be more accurate to characterise it as saying “yes, but . . .” Its recommendations have all cited evidence of clinical benefits, while only around half have cited cost per QALY. Many of its recommendations have specified conditions for use, such as subgroups of patients most likely to benefit. This in turn requires guidelines covering the full range of treatment options for the different groups of patients. This second, guideline, function of NICE may prove more important and challenging over the longer term, given the magnitude of the task and the paucity of evidence. By October 2000 NICE had published four guidelines and was working on a further 31, often for the same diseases as those for which guidance on technologies has been issued.

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