LETTERS TO THE EDITOR

The Cost-Effectiveness of Duloxetine in Chronic Low Back Pain: A US Private Payer Perspective

Our letter refers to the following publication: Wielage RC, Bansal M, Andrews JS, et al. The cost-effectiveness of duloxetine in chronic low back pain: a US private payer perspective. Value Health 2013;16:334–44 [1]. We would like to draw attention to several data inaccuracies in the mentioned article:

1. The pain level of patients in the different publications is not mentioned. We know from clinical trial experience with tapentadol that patients had moderate to severe pain (most even severe pain). Pain level of patients in studies with duloxetine, naproxen, and celecoxib might have been lower; at least we would extrapolate this from the dosages used. On the basis of this, we doubt whether the study populations are comparable and the comparators are appropriate. The patient who uses naproxen (or even cox-II) is not similar to someone who uses strong opioids.

2. The dosage that is used for the calculation of daily costs of tapentadol (Table 1 at http://dx.doi.org/10.1016/j.jval.2012.12.006) with up to 600 mg is not within the label (according to the SmPC, the highest dosage recommended is 500 mg/day) of the extended release formulation recommended for the treatment of chronic pain. The average dosages in clinical trials amount to around 300 mg, with those from market data even lower around 200 mg/day. The very high dosage used in the Wielage et al. article leads to the high daily costs for tapentadol, resulting in an unfavorable result for tapentadol in the cost-effectiveness plane.

3. The dosing for oxycodone extended release is not comparable to the dosing for tapentadol. Comparing the World Health Organization defined dose, which is 400 mg for tapentadol and 75 mg for oxycodone, this would be a factor of 5.3 (which is also reflected in the clinical trials in which oxycodone was used as active comparator [2]). The very low dosage used for oxycodone (10–30 mg) would be suitable for patients with mild to moderate pain, whereas the dosage of 600 mg for tapentadol is even beyond the one covered by the labeled indication and used in severe chronic pain and therefore these are not comparable.

4. Table 1 at http://dx.doi.org/10.1016/j.jval.2012.12.006: PPI (Proton Pump Inhibitor) use for all opioids is high, 21%. It is not clear why is this higher than for nonsteroidal anti-inflammatory drugs, and the source of these data is not given. Because the main adverse events for opioids are nausea, vomiting, and constipation (which cannot be treated with PPIs), we do not see a causal relationship between opioid treatment and the use of PPIs at all.

5. Table 1 at http://dx.doi.org/10.1016/j.jval.2012.12.006: How are “discontinuation drug costs” defined? Why are they so high for tapentadol than for other therapies? In clinical trials, the percentage of patients discontinuing the study is lower than for oxycodone [3]. This should lead to lower costs, not to higher costs.

6. Table 1 at http://dx.doi.org/10.1016/j.jval.2012.12.006 shows the same opioid abuse rates for tapentadol and oxycodone—data from the RADARS system [4] suggest otherwise.

In our view, these data inaccuracies lead to an unfavorable cost-effectiveness result for tapentadol, which we feel should be either more fully justified, or corrected.

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REFERENCES


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