Pharmacy-led switches of 5-ASA: impact on secondary care

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Received 11 June 2012

Revised 7 September 2012

Accepted 8 September 2012

Published Online First

12 November 2012

INTRODUCTION

Cost containment in prescribing budgets is, and always will be, a key priority in any health service with limited resources. Therefore, a number of primary care trusts (PCT) have recently initiated pharmacy-led switches of 5-aminosalicylic acids (5-ASAs), with the intention of reducing prescribing budgets. However, this has generated considerable controversy among gastroenterologists, as there is concern that the clinical consequences of such programmes have not been adequately explored.

PCTs are currently under no obligation to consult secondary care prior to initiating pharmacy-led switches. In a secondary care-led condition such as inflammatory bowel disease (IBD), this seems highly counterintuitive. If gastroenterologists were to be consulted, how would we respond, and what could we contribute? This article examines the clinical consequences of PCT-initiated switch programmes in IBD, and the knock-on effects on patients and the secondary care gastroenterology community.

DIRECT CLINICAL CONSEQUENCES

For a switch programme to be justified, the financial benefits it imparts must be balanced against its clinical effects. Here, we consider what the clinical effects of a 5-ASA switch might be. Many gastroenterologists express concern over such programmes, but is there evidence for a detrimental effect, and what is the experience that exists among the secondary care community to inform our approach?

Many gastroenterology specialists have already encountered pharmacy-led switches firsthand, and some of their experiences provide immediate cause for concern. Although anecdotal, reports abound that 5-ASA switches have been followed by flares of active disease and other adverse effects in a worrying number of patients. For example, in one

recent pharmacy-led switch programme, a patient showed a significant drop in his white blood cell count after his 5-ASA was changed, and another two patients experienced bouts of diarrhoea. In a particularly worrying case, a young woman who was very concerned about her 5-ASA being switched was subsequently admitted with an episode of supraventricular tachycardia.

Although emotive, such cases are limited in how far they can guide real-life practice. Crucially, the unpredictable and sporadic nature of flares makes a cause-and-effect relationship hard to establish. Moreover, there is a distinct paucity of robust evidence on the clinical consequences of 5-ASA switches.

Nonetheless, there is a growing consensus that the various 5-ASA formulations should not be considered interchangeable.^{1 2} Different 5-ASA formulations employ different mechanisms to deliver the active drug to the colon. These include pH-dependent release, time-dependent release and azo-bonded prodrugs, each giving rise to different release profiles in the gut.³ It is for this reason that the European Crohn's and Colitis Organisation recommends that 5-ASA should be prescribed by brand name.³ A change in the release profile of 5-ASA into the gut could be postulated to give rise to a change in disease control; in which case, switching formulations has the potential to affect the likelihood of a flare.

Switching may also have a psychological impact on the patients involved, with the potential for knock-on effects on treatment outcomes. Clinical experience suggests that the emotional disturbance is particularly acute when the switch is managed by a community pharmacist, rather than the IBD team they know and trust. The psychological impact of a switch may be mitigated by carefully discussing with the patient the pros and

To cite: Healey CJ, O'Malley J. *Frontline Gastroenterology* 2013;4: 88–90.

cons of the change in medication. Although this does not impact on the physiological consequences of a change in mesalazine release characteristics, a carefully explained approach may help to minimise the psychological burden of the switch. Conversely, an unexpected or unexplained change of medication can cause substantial anxiety, and there is increasing evidence to suggest that stress directly impacts the course of IBD through its physiological effects on gut function.⁴ Furthermore, concerns about medication are known to significantly affect adherence to medication,⁵ thereby putting patients at risk of the poor treatment outcomes associated with non-adherence (discussed below).

Given the lack of empirical evidence on the clinical outcomes of pharmacy-led switching in IBD, it may be pertinent to draw on lessons learned in other disease areas. Reliable comparisons between disease areas are inherently difficult to make, and caution is vital when making such comparisons; nevertheless, some useful insights may be gained. The issues surrounding switching have been much debated in the field of epilepsy in particular. Many epilepsy patients are able to achieve good control of their symptoms with medication; however, there is evidence to suggest that generic switches may be associated with a decrease in treatment success.^{6,7} The consequences of this are potentially catastrophic—a breakthrough seizure may result in loss of employment or even physical injury.⁶ As a result, generic substitution of epilepsy medications is broadly discouraged.^{6,7}

Applying this evidence to inform practice in IBD must be done cautiously, though a number of important parallels support the comparison. For instance, during the maintenance phase, IBD patients experience good control of their symptoms. However, during a flare, patients may experience a dramatic loss of health and a severe decline in quality of life.^{8,9} Given the potentially devastating effects of a flare, it might seem prudent to follow the example of epilepsy, and avoid pharmacy-led switches of 5-ASAs, at least until firm evidence of their safety becomes available.

KNOCK-ON EFFECTS: THE DOCTOR–PATIENT RELATIONSHIP

One element which is of vital importance is the effect of pharmacy-led switches on the doctor–patient relationship. There can be little argument that a strong relationship is an important element of patient-centred care in chronic disease. In IBD specifically, patients experience unpleasant and embarrassing symptoms, requiring careful emotional counsel and support from their doctor.

On one hand, carefully managed and explained switches, in which the pros and cons of the medication change are discussed with the patient in advance, need not disrupt the doctor–patient relationship. Conversely, switch programmes that do not

adequately involve or inform patients may substantially damage this relationship, an effect that is beginning to be considered in the primary care gastroenterology community.¹⁰

A vital ingredient to this relationship is that doctors are perceived to be acting in the best interests of their patients, free from outside influence and non-clinical motivation. Although flares in IBD are generally unpredictable, some patients may associate any adverse outcomes with the switch, whether truly causal or not, leading them to blame their doctor for their loss of health. A recent case that illustrates this point involved a patient who blamed a flare on a pharmacy-led switch in his 5-ASA medication. When he later required immunomodulator therapy, he was reluctant to undergo treatment, stating that he had lost trust in his care team.

This example demonstrates that the trust element of the relationship is crucial, and that this trust may be substantially eroded by an unexplained switch—particularly if patients are not informed in advance. Again, we can draw useful parallels with other conditions; this view is further supported by a survey of asthma patients, whose inhaler devices were switched without their prior knowledge. A large proportion of the patients involved felt that the decision had not been made in their best interests, and had damaged their relationship with their doctor.¹¹

It is important to consider that anything that results in damage to the doctor–patient relationship may affect the supportive role of consultations, leading to further adverse outcomes, potentially initiating a vicious cycle.

ADHERENCE

Supporting adherence to long-term therapy is a key element of IBD care, and may be particularly relevant when considering the effects of pharmacy-led switches. Non-adherence to 5-ASA therapy is known to affect the risk of flare. Indeed, one study reported that patients with ulcerative colitis in remission who were non-adherent were five times more likely to relapse than adherent patients.¹² Combined with the increasing evidence for a chemoprotective effect against colorectal cancer, the data provide a strong indication of the importance of adherence to regular long-term 5-ASA therapy.¹³

An unexpected change in medication could potentially directly affect adherence. If patients are concerned about the new medication, or lose belief in it, this could significantly increase the risk of non-adherence. Furthermore, there may be an indirect effect, through damage to the doctor–patient relationship. Doctors play a pivotal role in supporting adherence, but if the relationship between the doctor and the patient is damaged, this role may well be affected.

CONCLUSIONS

Gastroenterologists have expressed significant concerns regarding pharmacy-led switches in 5-ASA formulations. Although robust evidence for a detrimental effect of switches is currently elusive, there is certainly sufficient evidence to exercise considerable caution. Naturally, containment of prescribing costs is a key priority in today's health service. However, the modest financial benefits of switch programmes cannot be justified if they are at the expense of patients' quality of life and disease control. If such switch programmes are indeed detrimental to patient care, we must consider whether there are any alternative ideas that could free up resources. For example, it may be more effective to invest in patient education, adherence support or integration of primary and secondary care, in order to realise long-term savings combined with improvements in patient care.

In the emerging National Health Service (NHS), increased clinical engagement with commissioning decisions is expected to become widespread. In this context, secondary care must be prepared to play a prominent role, acknowledging the value of financial savings while ensuring that the highest quality of care is maintained.

Acknowledgements Editorial assistance was provided by Acumen Healthcare Communications. Warner Chilcott UK Ltd sponsored the preparation of this article and contributed to its development.

Contributors CJH and JO'M hereby confirm that they contributed to the development of this manuscript as authors, contributing to its conception and preparation and providing final approval of the manuscript. Editorial assistance was provided by Acumen Healthcare Communications.

Funding Warner Chilcott UK Ltd sponsored the preparation of this article and contributed to its development.

Competing interests Dr Healey has received sponsorship for meetings from Warner Chilcott UK Ltd, and has acted as a clinical advisor to Ferring Pharmaceuticals Ltd. Dr O'Malley has received sponsorship for meetings from Warner Chilcott UK Ltd.

Provenance and peer review Not commissioned; externally peer reviewed.

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