Trends-in-Medicine

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Quick Pulse

Trends-in-Medicine
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THE FAMILY MEDICINE PERSPECTIVE

Family medicine doctors often write more prescriptions for particular medicines than their specialist counterparts, so understanding their attitudes toward a variety of topics and their clinical practices are very important in determining the outlook for new drugs and devices as well as expanded labels for existing products. The American Academy of Family Practice (AAFP) annual meeting in Chicago from October 4-6, 2007, was attended by more than 5,000 family doctors, and 62 of them (yes, 62 – an interviewing marathon) were questioned on a number of issues, from cholesterol and diabetes medications to the human papillomavirus (HPV) vaccine and drugs to treat hypertension, gastrointestinal disorders, arthritis, and allergies, etc. They were also asked about managed care issues and electronic prescribing (e-prescribing).

Allergy

There was a surprising lack of advertising for allergy medications at this meeting. Schering-Plough had a small booth promoting over-the-counter (OTC) Claritin (loratadine) but not its Nasonex (mometasone furoate) nasal spray. MedPointe was promoting its Astelin (azelastine Hcl) nasal spray, but AstraZeneca and GlaxoSmithKline (GSK) didn't have any samples, signage, or promotional materials at their booths about any of their allergy products.

GSK wasn't even promoting its new allergic rhinitis nasal spray, Veramyst (fluticasone furoate), and most of the doctors questioned about Veramyst either hadn't heard about it or hadn't tried it yet. An Ohio doctor said, "I just saw a commercial for Veramyst, but before I try it, I need to know how it differs from Flonase (GSK, fluticasone propionate), which just went generic. It lights up a red light that Flonase just went generic and suddenly this is available. Is it a patent-extension gimmick?" An Illinois doctor said, "I've heard about it, but I haven't used it yet." A Michigan doctor said, "I tried Veramyst in one patient because I had a sample, but I haven't seen that patient back yet, and I'm waiting to see how that patient is doing." A Tennessee doctor said, "I just started using Veramyst, so I don't have any patient feedback yet. I started because of the claim that it reduces ocular symptoms, but that's hard to believe. I want to see if that is really better. If so, it would be great."

Electronic prescribing

Electronic prescribing is definitely catching on. Most sources in large practices either have it already – mostly as a part of their electronic medical record (EMR), but occasionally as a stand-alone product without an EMR – or are in the process of choosing an EMR vendor. An Illinois doctor said, "Of all the electronic innovations in our office, that (e-prescribing) is probably the one we've adopted the most." A California doctor said, "We have Allscripts. You get used to it. The

problem is when I go to an office or clinic that doesn't have e-prescribing, and I have to write a paper prescription. I sometimes have to stop and think about doses, which I don't have to do with e-prescribing."

Small, private practices are the laggards, and the main reason is cost. A West Virginia doctor said, "The availability is still limited in West Virginia. We had an EMR with e-prescribing, but it was too cumbersome to use." An Oklahoma doctor said, "We are working on getting an EMR installed over the next one to three months, and it will include e-prescribing." Another doctor said, "I'm not sure if we will start e-prescribing because we are a small practice." A Michigan doctor said, "We are in the process of picking an EMR vendor that will include e-prescribing. We didn't want just a piece, so we didn't get only e-prescribing."

Among the e-prescribing programs used or being considered by these doctors are:

- Allscripts. This was the most commonly cited provider in use or being considered.
- iMedica.
- Pepid.

Type 2 diabetes

The two FDA-approved thiazolidinediones (TZDs) for Type 2 diabetes – GlaxoSmithKline's Avandia (rosiglitazone) and Takeda's Actos (pioglitazone) – have been shown to be effective in reducing the surrogate endpoints of blood glucose and hemoglobin, but both are associated with a substantial increase in the risk of heart failure, and the FDA has added warnings about this to the label of both drugs. The question is their cardiovascular safety. In May 2007, Dr. Steve Nissen and Kathy Wolski of the Cleveland Clinic published a 42-trial meta-analysis of Avandia in the ***New England Journal of Medicine*** which showed a 43% increase in the risk of myocardial infarction (MI) (p=0.03). That ignited a firestorm over the safety of TZDs in general and Avandia in particular.

The FDA held an advisory committee meeting on Avandia on July 30, 2007, with the panel voting (a) 20 to 3 that Avandia is associated with an increased CV risk, but (b) 22 to 1 that Avandia should remain on the market with a black box warning about the CV risk. The FDA has yet to announce what it plans to do about Avandia or Actos with respect to CV risk.

Then, on September 12, 2007, two new meta-analyses were published in the ***Journal of the American Medical Association (JAMA)***, suggesting that the CV risk with Avandia may ***not*** be a class effect. The analyses found that Actos and Avandia both can cause heart failure but differ strikingly in their CV safety profile.

Doctors at AAFP generally believed that there is a difference in the safety of Actos and Avandia. An Iowa doctor said, "The recent ***JAMA*** article makes it appear there is a difference. I thought it was convincing." Another doctor said, "Actos does appear safer." An Illinois doctor said, "If a patient needs a TZD, I tend to lean to Actos. Studies tend to indicate that Actos is safer." A North Carolina doctor said, "The data say there is a difference, that there is better heart protection with Actos, but I'm not sure."

Doctors also were questioned about how their prescribing practices for diabetics have changed since this controversy arose.

- None is starting new patients on Avandia, but they generally are continuing patients on it who have been doing well on it – unless the patient asks to be taken off.
- Most are still starting new patients on Actos, but usually not first-line – only when metformin fails to achieve the goal. A Wyoming doctor said, "I still start new patients on a TZD, but I lean to Actos more because it has been proven safer. Takeda claims Actos is safer. We'll see." A Florida doctor said, "Patients prefer Actos. They refuse Avandia because of the news stories. It is like Celebrex and Vioxx. Patients will take Celebrex and Actos, but not Avandia."
- Avandia patients who wanted (or want in the future) to stop were switched, mostly either to Actos or to insulin. Some are just having the Avandia withdrawn to see how they do without it. A Utah doctor said, "Patients in good control stay on Actos or Avandia. Those out of control are going on insulin." A Wyoming doctor said, "I typically discontinue the Avandia and see how they do with the other medications they are taking." An Iowa doctor said, "I'll be using a lot more insulin over the next year – not first-line, but if a patient is not achieving goals after metformin…I participated in a pay-for-performance project with 135 diabetic patients, and I got Hb_{A1c} from 60% <7 to 83% <7 by being aggressive with metformin, some Byetta, TZDs – a lot of combination therapy."
- Another few Avandia patients are being switched to Merck's new DPP-IV, Januvia (sitagliptin). A North Carolina doctor said, "I don't switch patients from Avandia to Januvia, but I do add Januvia to metformin." An Iowa doctor said, "I'm changing Avandia patients who worry about heart failure – people who are concerned and read about the TZD controversy – to Januvia."

About half these doctors have started using Januvia and Januvet (sitagliptin + metformin), but they are not using it first-line. In fact, it usually is viewed as a third-line agent, after (1) metformin and (2) a TZD. On average, they estimated that 11% of their diabetic patients are on Januvia or Januvet. In part this is because Januvia and Januvet are new, but it is also due to the cost and not being on many formularies yet. A Washington DC doctor said, "Januvia is not reimbursed by Medicare or Medicaid."

Doctors who have tried Januvia say they haven't seen any issues with tolerability or side effects, but most are either not very impressed with the efficacy or say it is too early to determine how well it works.

- *Michigan:* "Efficacy is not as good as a TZD, but there are no safety or tolerability issues, so you are trading a little effect for a lot of safety."
- "It is too expensive, and the efficacy is not that good – about comparable to Actos."
- *Utah:* "I haven't used Januvia enough to get a sense about it yet, but there haven't been any unusual side effects."
- *Minnesota:* "I'm not very impressed with Januvia. I think there is a lack of efficacy. I haven't seen anyone where it made a significant difference, but maybe I'm using it too late. There is no issue with side effects, and tolerance is fine."
- *Illinois:* "I have very few patients on Januvia. It sounds good theoretically, and it is well tolerated, so use will probably increase over the next year."
- *Iowa:* "It probably drops Hb_{A1c} one point. I'm impressed, and safety and tolerability are excellent."
- *Washington:* "I just started Januvia. It seems to be doing okay, with not a lot of side effects. It is useful in the same patients who would usually start metformin, which is my first-line choice. Januvet is somewhat more appealing – if it is covered by insurance because it would mean only one co-pay for patients. For metformin patients, I will usually add Januvia first to see how they do, and then change them to Januvet if it is covered…The efficacy is good, but the effect tapers off after about four weeks due to a little resistance or tolerance developing."

Over the next 12 months, doctors predicted their use of Januvia and Januvet would increase to an average of 19% of their diabetic patients, provided it gets covered by more insurance companies and appears on more formularies. A doctor said, "Now, Januvia is insurance's last choice, and Januvet is used very little; it's a third or fourth choice."

Lilly/Amylin's Byetta (exenatide) is not very popular with these doctors. Most have only a few patients on it, and very few expect use to increase over the next 6-12 months. They said there is no patient demand for Byetta, the nausea and injections are issues, cost and lack of insurance coverage limit use, and some patients not only don't lose weight but they gain it. Comments included:

- *Minnesota:* "I haven't started anyone on it, but I have a handful of patients who came to me on Byetta. The hurdle is the cost and lack of familiarity, plus there is no particular benefit. It is not an injection issue."
- *Utah:* "The issues are injections and insurance. Insurance companies are not covering it as well as would be nice, and they are making us do too much paperwork."
- *Midwest:* "If I have to choose between Januvia and Byetta, I lean to Januvia because it is oral. Byetta's injection is a hurdle, and the nausea with Byetta is an issue. Patients don't ask for Byetta because of the purported weight loss. I'm afraid I've seen weight ***gain*** with some patients."
- *Michigan:* "I wish I were using Byetta. I would if I could convince people to use it. No one wants a shot."
- "I haven't used any Byetta at all yet. I'm not sure why, but I have a lot of established diabetics."
- *Washington:* "I tried Byetta, but a lot of patients didn't want to stay on it because of the nausea. All of those who stopped did so because of the nausea."
- *North Carolina:* "Our use increased to about 10% of patients when we no longer had to refrigerate it, and use is likely to increase because a lot of patients are losing weight and their sugars are better. Nausea is not a problem yet."
- *Iowa:* "The carrot is the weight loss, and patients are willing to take a shot to do that. I demonstrate the shot, and it is less painful than a finger stick. The hurdles are cost and insurance coverage, plus 10%-20% of patients can't tolerate the nausea."
- *Florida:* "I don't have any patients on Byetta. I tried it in a few patients, and they gained weight on it. So I don't use it much, and the injections are an issue."

Long-acting Byetta (exenatide LAR) is in development as a once-a-week (QW) injection, but it may use a 23 gauge needle. Doctors are enthusiastic about the idea of a QW version of Byetta, and they said that would normally boost their use of Byetta, but they said the needle size may be a significant barrier. Comments included:

- "Once-weekly is appealing, but patients wouldn't take it with a 23 gauge needle. They wouldn't like that size needle."
- *Illinois:* "QW would increase use. People would get used to the needle."
- *Wyoming:* "With LAR I would worry more about hypoglycemic events more than the needle size. I would need to be detailed on it. QW is appealing, but I'm worried about hypoglycemia."
- *Utah:* "QW is good, but people might not want to do a 23 gauge needle. That could be a hurdle unless the patients could get someone else to give the injection to them."
- *Iowa:* "QW is very interesting. If it doesn't increase nausea, it will be appealing."
- *Minnesota:* "It sounds interesting, but a 23 gauge needle could be an issue. 23 would definitely give me pause. I use a 22 gauge needle for injecting knees and shoulders. That is a good-sized needle."

- *Washington:* "The question is what the nausea will be with LAR. A 23 gauge needle is not a big issue, but patients will feel it, and they probably will want their spouse to administer it. I'm not sure I could inject myself with a 23 gauge needle."
- *Michigan:* "QW would be ideal, but I wouldn't stab myself with a 23 gauge needle."
- *North Carolina:* "I don't like needles, but I really don't know if the needle size is a problem. I would like a QW version, so I am looking forward to it."

Gastroesophageal reflux disease (GERD)

On average, doctors estimated that 15% of their GERD patients are not well-controlled on a once-daily proton pump inhibitor (PPI). However, doctors are generally very satisfied with the efficacy of PPIs.

PPI use has not been affected recently by any safety concerns, doctors insisted, but it has been affected by formulary changes. A Nevada doctor said, "The new osteoporosis fracture risk has made us think about it, but it hasn't changed what I prescribe. And there are no other options for these patients because they don't want to modify their diet and lifestyle." A Michigan doctor said, "More formularies are specifying Prilosec (AstraZeneca, omeprazole) and Zantac (GSK, ranitidine Hcl) because they are on the Wal-Mart $4 list." A Tennessee doctor said, "Some patients have a problem with absorption of iron, vitamin B-12, or folic acid, and I tell them that their PPI could be involved."

If there were another well-tolerated agent that could be combined with a PPI to further treat GERD, these doctors would be open to it – even if the cost were 15%-20% higher than a generic PPI. A Nevada doctor said, "We keep waiting for something better – if it were covered by insurance. Medicare patients now specifically ask for a generic PPI, so it would be difficult in the Medicare population." A Wisconsin doctor commented, "Why have another drug? We don't need it." A Texas doctor said, "If it works, it would be appealing, but it is a small population."

Human papillomavirus (HPV) vaccine

The uptake of Merck's Gardasil was described as "tremendous" among females under the age of 18 or 19, with most girls and their parents agreeing to the vaccine. The problem is with females over the age of 18 or 19. Doctors said insurance rarely covers Gardasil for them, and very, very few are willing to pay for it on their own. Occasionally, a health department will provide it at an extremely reduced rate ($7-$10 vs. the typical $360 for 3 shots at the doctor's office).

Comments included:

- *Illinois:* "I've had excellent compliance. Now that it is available at the local health department, 75% of eligible patients are getting it."
- *Indiana:* "Fifty percent of eligible patients have taken it. Those who haven't accepted it are due to either parental moral conflict, some financial concerns because it is not reimbursed by all carriers, or a decision to postpone getting it."
- *Washington DC:* "One hundred percent of my eligible patients under 18 are getting it. Over 18, no one is getting it. Insurance tends not to cover them, and few elect to pay for it themselves. They want it, but they won't pay for it."
- *New Jersey:* "So far, about 10%-20% of eligible patients have had the vaccine. It is getting easier and easier to get patients to get the vaccine. Patients already know about it. They come in and ask about it."
- *Washington:* "Under 18, 90%-95% accept it. Over 18, it is also covered where I am, so more than 90% of them also get it."
- *New York:* "A lot of patients ask about Gardasil, which doesn't happen with other vaccines. Women over 18 are interested in Gardasil, but they can't get it paid. There is little patient or parent resistance to Gardasil. They all want it but not one will pay $360 for the three courses."
- *Michigan #1:* "Over age 19, only about 2% of eligible patients get it because they are not covered nearly as well as young patients. The health department covers girls under 19 but not over 19. So, under 19, 35%-40% of eligible patients have had it, and we are actively marketing it. We mention it to all girls. The other 60%-65% turn it down because they want to wait, say it's too new, want to think about it, or have a moral issue with it."
- *Michigan #2:* "Very few patients under age 18 reject it, and about 40%-50% of girls over 18 get it – those with insurance companies that pay. Single patients without coverage tend to pay, but if they are married and don't think they need it, they don't get it."
- *California (health department):* "All of the girls under 18 are getting it. Over 18, we are trying to give it. We were afraid we would run out, so we didn't push it with older girls, but we haven't run out, so we are getting more aggressive with older patients. For them, it usually isn't covered by insurance, so we eat the cost. Maybe 25% refuse it."

Hyperlipidemia

Insurance companies are pushing doctors to prescribe more generic statins, particularly simvastatin and, to a lesser extent, pravastatin. And simvastatin use is increasing, doctors agreed. A California doctor said, "I'm using a little more simvastatin. Personally, I avoid Lipitor because there is more myalgia with it." A Wisconsin doctor said, "The increase in simvastatin use is driven by formularies." A Pennsylvania doctor said, "My simvastatin use is relatively flat, but I'm using more Lipitor, especially if patients have had a stroke or TIA (transient ischemic attack)." A Louisiana doctor said, "The biggest

formulary change I've seen (in cholesterol medications) is the addition of Crestor."

For less well-controlled patients, doctors have become more aggressive in up-titrating the dose before moving to a more potent agent, such as AstraZeneca's Crestor (rosuvastatin), Pfizer's Lipitor (atorvastatin), or Merck/Schering-Plough's Vytorin (simvastatin + ezetimibe). Concerns over the safety of Crestor appear to have decreased. A California doctor said, "I maximize dose before switching to something else. My experience is that Lipitor is very good but has more side effects. I used to put (less controlled) patients on Lipitor, but now I maximize other drugs first." A Pennsylvania doctor said, "I up-titrate patients as long as the patient tolerates it. If the patient's triglycerides are high, then I go to combination therapy." A Louisiana doctor said, "We maximize dose before going to another agent, and that's what we're teaching our residents, but go to a more potent agent for people with risk factors (coronary artery disease, diabetes, etc.) – we have a whole algorithm for that."

When they do need one of these stronger agents, how do they choose among them? An Indiana doctor said, "Crestor and Vytorin are better than Lipitor, but often patients are more willing to deal with the side effects of up-titration than the cost of a brand drug." A California doctor said, "Mostly I use Lipitor. I've used Vytorin a little, and I've started a few (of these) patients on Crestor but not many." A Wisconsin doctor said, "The formulary dictates my choice." A Pennsylvania doctor said, "Crestor use is up because of insurance companies." A Louisiana doctor said, "Formulary is important, but, honestly, it is also access – and price – that dictate what patients get. We are using more Lipitor because it is $4 at Wal-Mart."

Vytorin still has traction; the novelty isn't dying, doctors agreed. A California doctor said, "My attitude is slowly changing (positively). What I do is use it for patients who have bad myalgia on Lipitor or another statin." A Pennsylvania doctor said, "I use Vytorin when the patient has a problem with more than LDL cholesterol – also high triglycerides or low HDL." A Louisiana doctor said, "My use of Vytorin is still increasing. I'm using it more and more and more every day."

Merck/Schering-Plough's Zetia (ezetimibe) is rarely prescribed as monotherapy by these doctors, but occasionally it is added to a generic statin. An Indiana doctor said, "I don't use Zetia often. It makes more sense for a brand co-pay to be Vytorin unless insurance won't pay for Vytorin but will pay for Zetia." A Pennsylvania doctor said, "I use Zetia when only HDL is a problem." A Louisiana doctor who uses a lot of Vytorin said, "I never use Zetia."

Niacin is considered a good agent for boosting HDL and decreasing triglycerides, but doctors have been reluctant to prescribe it because too many patients can't tolerate the flushing side effect (itching, tingling, redness/rash, and warmth) and many doctors do not want to deal with it. Flushing is reduced with extended release niacin like Abbott/Kos's Niaspan, but it is still a barrier to use.

Merck is developing Cordaptive (extended release niacin plus laropiprant), which, in data presented at the European Society of Cardiology meeting in September 2007, cut flushing from 22% with extended release niacin alone to ~10% with Cordaptive.

Asked about the outlook for Cordaptive if it gains FDA approval, doctors at AAFP were cautiously enthusiastic. All said they would give it a try. An Indiana doctor said, "I absolutely would try it. My success with niacin is very, very low because of flushing. I tried taking niacin once myself, and the flushing was horrible. So, I would be interested if a niacin had less flushing." A California doctor said, "I'd have a little interest, but niacin is not good in diabetics because it raises their glucose, and so many patients are diabetics. There is a role for niacin, but I don't leap into new medications." A Wisconsin doctor said, "It would increase my niacin prescriptions because niacin is effective. If only 10% of patients have flushing, that means 90% won't." A Louisiana doctor said, "Niacin is great for lowering triglycerides, and it is a good option for patients who can't tolerate statins, but I don't use much Niaspan. Before I use Cordaptive, I want to see studies that show outcomes data."

Hypertension

Family doctors also are up-titrating and being more aggressive with the dose of anti-hypertensive agents for patients not meeting goal. A New Hampshire doctor said, "Blood pressure of 140/90 is the standard goal, but I target 130/85 and for diabetics 125/75. If there is protein in the patient's urine, it suggests inflammation, and decreasing the protein with an ACE inhibitor or an ARB decreases the risk of dialysis – and ACE inhibitors and ARBs delay diabetes by 10 years. I have the equipment in my office to check patients for protein in the urine." A Virginia doctor said, "I'm doing more up-titration and being more aggressive because the evidence of earlier and more aggressive intervention improves outcomes for cardiovascular disease."

Most patients with hypertension are already on combination therapy with two, three, or even more medications. A New Hampshire doctor said, "It is almost a must to start with two agents; 60%-70% of my patients get 2. For every 10 points a patient is over 130 systolic blood pressure (SBP), you need one medication, so for a patient with SBP 180, you need 4-5 medications." A Virginia doctor said, "I definitely do double and triple combinations, and sometimes I do quadruple therapy. But it is hard for patients to understand when they have to take multiple drugs. It gives them the perception that they are really sick." A North Carolina doctor said, "The recommendation of JNC-VII is that most patients with hypertension should be on a minimum of double therapy. One has to be a diuretic, and No. 2 is an ACEi or an ARB." An

Illinois doctor said, "80% of my patients are on ≥2 medications."

Novartis's Tekturna (aliskiren), a first-in-class renin inhibitor approved by the FDA in March 2007, has made few inroads with these doctors. Only a few have tried it yet – often because it is not on their formularies – and some were not even aware of it. A New Hampshire doctor said, "I'm not sure there is an advantage to Tekturna, but it probably will get used for diabetics, but it isn't better than Diovan (Novartis, valsartan, an ARB)." A North Carolina doctor said, "I'm aware of it, but I haven't tried it yet. Eventually, I will try it, but it is not on formularies yet, and the studies are too early." A New York doctor said, "I haven't tried it yet, but when I do, it will be reserved for third-line." An Illinois doctor said, "I'm aware of it, but I haven't tried it. Use will depend on whether it gets on the formularies."

Cardiac resynchronization therapy (CRT)

Electrophysiologists (EPs) have said that referrals for CRTs combined with defibrillation (CRT-Ds) have slowed, but heart failure specialists interviewed recently said their referrals have been steady. Are family practice doctors referring fewer patients to EPs for CRT-Ds? Not according to sources at AAFP. All but one of these primary care doctors refer patients they think would benefit from a device to a medical cardiologist for further evaluation, and then that cardiologist refers the patient to the EP. And family doctors said they haven't seen any dip in their referrals to cardiologists. However, a Nevada doctor noted, "Our cardiac patients are much better managed today. We are not admitting as many CHF exacerbations as we used to." Another doctor agreed, saying, "CHF patients are taking their medications better."

Managed care

Formularies are tough, and they are getting tougher for physicians and patients, doctors generally agreed. An Illinois doctor said, "Formularies may be getting tougher for ***patients*** because sometimes we write the wrong prescription for their formulary, and then the pharmacist changes it, and it inconveniences the patients." A California doctor said, "Patients feel pressured, with the workplace cost of insurance going up, co-pays going up, and non-formulary co-pays going up. Insurance companies are about making money and denying services, and they usually don't allow expensive new drugs, but patients want those drugs and want someone to pay for them. In medical school I learned to know a few drugs and know them well, but if my front office doesn't get a patient's formulary right, then I will get a sad face from my e-prescribing program. That slows the train (in the office). Tell me how that is cheaper?" A Texas doctor said, "We had to hire an extra person to handle the prior authorizations." A West Virginia doctor said, "The biggest issue is that insurance companies keep changing the formularies all the time. As a result, I initially prescribe what I think the patient needs, and the pharmacist gives the options. That's time-consuming for new medication starts, but I still pick the best medication." An Oklahoma doctor said, "As more drugs go generic, it is getting easier for us…I always use the cheapest drug that meets the patient's needs." A Texas doctor added, "A big problem is seniors with Medicare Part D. At first all their medications were covered, and now plans can select, so there will be more changes."

Most doctors are doing more therapeutic substitutions, and they are also seeing a continued trend toward more step therapy, where they have to start with a generic first and work their way up to more expensive and newer brand name products. An Illinois doctor said, "The move to step therapy is not just driven by managed care. Wal-Mart and others are educating patients about generics." A Texas doctor said, "It is definitely harder to use brand name products." A West Virginia doctor said, "I'm prescribing more generics because more are available, but the emphasis on step therapy has increased over the last 18-24 months."

Obsessive compulsive disorder (OCD)

Most family doctors questioned said they treat OCD patients, but many of them refer the patients to a psychiatrist to start a medication, then they follow them. Those who do start OCD therapy themselves often use Solvay Pharmaceuticals' Luvox (fluvoxamine), and they are very receptive to the company's longer-acting, once-a-day version (Luvox CR), which is awaiting FDA approval and will be marketed in the U.S. by Jazz Pharmaceuticals. An Ohio doctor said, "OCD is a niche for Luvox. I never use it for anything else, so I would probably try Luvox CR for OCD." A Washington doctor said, "I use Luvox, and I'll use Luvox CR. A lot of patients are on more than one medication and would like a once-a-day Luvox." A Tennessee doctor said, "Luvox is my first-line treatment for OCD, so Luvox CR is very interesting."

Pain

For osteoarthritis (OA), use of Pfizer's Celebrex (celecoxib) is decreasing somewhat for most of these doctors. Usage is flat for some, but none reported an increase in Celebrex use. An Illinois doctor said, "My Celebrex use is down for the usual Vioxx (Merck, rofecoxib) safety reasons. But I've always been a minimalist in NSAIDs for OA because I think the side effects are not worth it." An Oklahoma doctor said, "I'm using less Celebrex because I don't want to get into the issues involved (with Cox-2 inhibitor safety)." A Michigan doctor said, "Celebrex use is down because of the (Vioxx) publicity." Another doctor said, "My Celebrex use is decreasing because insurance is not covering it." A South Carolina doctor said, "Celebrex use is continuing to go down because there is still a cardiovascular concern." An Ohio doctor said, "I rarely use Celebrex because of the Vioxx issues." A doctor from Hawaii said, "My Celebrex use is declining. I try to reserve it for OA and RA (rheumatoid arthritis) patients who do not respond to a non-selective NSAID."

For neuropathic pain, family doctors generally prefer these drugs – and in this order:

a. **Gabapentin** (Pfizer's Neurontin or the generic).

b. **Pfizer's Lyrica** (pregabalin).

c. **Lilly's Cymbalta** (duloxetine). A Nebraska doctor said, "My use of Cymbalta is increasing because it is newer." An Illinois doctor agreed, "Cymbalta use is increasing. It's another choice for hard-to-treat patients. I use it more in younger, healthier patients." A Tennessee doctor said, "I use Cymbalta if I'm concerned that the patient has depression as well, but all SSRIs or Effexor (Wyeth, venlafaxine) can be used as well." An Ohio doctor said, "All I use Cymbalta for is neuropathic pain. I have one patient who did really well on it, but the others haven't been on it long enough to say how well it works." A South Carolina doctor said, "Cymbalta use has increased for neuropathic pain, but most commonly I use gabapentin." An Ohio doctor said, "I use Cymbalta for neuropathic pain, but my use is fairly steady. I'm more likely to try Lyrica or gabapentin." Another doctor said, "I most often use Lyrica for neuropathic pain, though occasionally I prescribe gabapentin. Cymbalta is not my first choice. In some trials, it was no better than Lexapro (Forest Laboratories' escitalopram) or Effexor XR." A Washington DC doctor said, "I never use Cymbalta because there is no insurance coverage." A Tennessee doctor said, "I have a few patients on Cymbalta, and I'm not very impressed."

Sleep apnea

All of the doctors questioned said they "often" see sleep apnea in their patients, and when they do, they recommend sleep studies. A Maryland doctor said, "If a patient is symptomatic – if a spouse complains of snoring, the patient is diabetic with a waist circumference >40 inches or a neck >18 inches, I'll recommend a sleep test. And I'll sometimes suggest it for fatigue, for specific insomniacs, or for patients with certain sleep symptoms." A California doctor said, "As soon as a patient tells me about sleep apnea symptoms, I refer that patient for a sleep study." A Texas doctor said, "I refer patients as quickly as possible, even at the first visit. I use a questionnaire to find out about sleep apnea problems." A West Virginia doctor said, "Usually, I refer a patient for testing as soon as I recognize they have sleep apnea because it is hard to tell how severe it is until they are tested."

These doctors aren't reluctant to recommend sleep studies, and their patients are pretty receptive to the suggestion. The problem generally isn't with the testing; it's with the insurance companies and with patient resistance to treatment when sleep apnea is confirmed. A West Virginia doctor said, "There is lots of insurance resistance, and if a patient is not symptomatic and can't see the connection to a disease like hypertension, it is hard to convince the patient – until they become symptomatic. Usually, sleep apnea is recognized when the patient says his wife has been nagging him to tell me about his snoring all the time, and the wife says he stops breathing." A Maryland doctor said, "There is minimal resistance to testing. What people resist is if they have to go back for CPAP (continuous positive airway pressure) titration. I tried doing a CPAP test in my office, but it took too long, and there was no reimbursement, so now I refer those patients out." A California doctor said, "Some insurance companies fight it (the test). It's expensive. Most HMOs deny it, you appeal, and then it goes through. That wastes time and adds to the burden, but that doesn't make me less likely to prescribe a test." A Texas doctors said, "Patients have some resistance to testing when they find out what treatments there are if they are diagnosed with sleep apnea. Patients don't turn down the test. The problem is when they find they need to sleep under a mask." A Tennessee doctor said, "I have a huge number of patients with sleep apnea, and I send them for a sleep test. Some patients even request a sleep test. The hardest thing is not getting the test, but getting patients to use the CPAP."

Testing

Family doctors expressed little interest in either test they were asked about:

- **Platelet function** (aggregation), such as Accumetrics' VerifyNow assay for Plavix (clopidogrel) resistance.
- **Home INR testing** for their Coumadin (warfarin) patients. An Illinois doctor said, "Patients don't have the resources for this." An Oregon doctor said, "The idea isn't bad, but funding is an issue; we are a county clinic." An Indiana doctor said, "I have one patient with his own INR testing machine, and it is accurate and reliable, but a lot of seniors are not comfortable with doing their own testing, and it is expensive. I would support the use if a patient wanted to do it, but that's the only patient with any interest in it."

Other

Doctors were asked what other changes they've noticed recently in their practices. Responses included:

- **Extended oral contraceptives that delay menstrual periods.** A New Jersey doctor said, "Seasonique and Seasonale (Barr Pharmaceuticals/Duramed) are used by a lot of women, and Yaz (Bayer) is incredibly popular because of the advertising that it also works for acne and pre-menstrual disorder. One-third to one-half of the college age women on an oral contraceptive are on Yaz. It is fantastic marketing."
- **Smoking cessation.** A Michigan doctor noted that Pfizer's Chantix (varenicline) is really catching on. He said, "It works great if the patient sticks with it."
- **Cosmetic procedures.** Thermage, Palomar, Cynosure, and a few other cosmetic device companies had booths at AAFP, and there was a lot of interest. Despite the credit crunch and falling consumer confidence, sales reps and doctors questioned said they haven't seen any decline in

demand for cosmetic procedures. Several pointed out that the subprime mortgage market is not the demographic on which they depend for customers. One said, "If people were worried about losing their job it might be different, but they aren't." However, an industry source said procedure volume appears to have flattened.

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