

Pharmaceutical Economics & Health Policy

Editorial Comment

Concern over the safety of calcium channel blockers in hypertensive patients was first sparked by a case-control study by Psaty et al.¹ The authors found that the incidence of myocardial infarction was higher in hypertensive patients treated with calcium channel blockers than in those treated with a diuretic or beta-blocker. The safety of calcium channel blockers was again called into question by the results of a meta-analysis by Furberg et al,² which suggested that calcium channel blockers as a class may cause an increase in overall mortality in patients with coronary artery disease. The authors of these articles offered several possible explanations for these findings: negative inotropic effects; proarrhythmic effects; prohemorrhagic effects; proischemic effects; and, for short-acting dihydropyridines, a reflexory increase in sympathetic activity, theoretically leading to plaque rupture. As an observational case-control study, the investigation by Psaty et al was deemed to have several limitations.³ Buring et al⁴ and others⁵⁻¹¹ suggested that whereas the findings of Psaty et al may have been hypothesis-generating and potentially important from a research perspective, the results were nondefinitive from the viewpoint of either health care providers or hypertensive patients. Even if the claims were true, the known risks of uncontrolled hypertension may exceed the postulated hazard associated with the use of calcium channel blockers. In contrast to the results published by Furberg et al, a recent evaluation¹² found no increased risk of mortality between recipients and nonrecipients of calcium channel blockers (short-acting nifedipine, diltiazem, and verapamil) in a cohort study of 11,575 patients with coronary artery disease, with an average follow-up of more than 3 years. Leader and Mallick here provide an in-depth commentary regarding the methodologic issues and findings surrounding this controversy.

Holzer and colleagues use patient-level paid-claims data to quantify the financial burden associated with the treatment of ulcers of the lower extremities among patients with diabetes mellitus. Results stemming from the cost-of-care model indicate that expenditures exceed \$4500 per episode, and over \$2000 per patient, per year.

The majority of venous thrombi originate in the veins of the lower extremities; specifically in the valve-cusp pockets or bifurcations in the calf.¹³ The potential consequences associated with the development of deep vein thrombosis (DVT) include venous valvular damage, postphlebotic syndrome, tissue hypoxia, and/or embolization.¹³ In this issue, Hawkins and associates present a decision-analytic model designed to discern the cost-effectiveness of pharmacotherapeutic options for the prevention of DVT among patients undergoing knee replacement surgery.

Schizophrenia is a major psychotic disorder than can impair all aspects of a patient's life and carries a high risk of suicide and other life-threatening conditions.¹⁴ Because of the early age of onset and chronic nature of schizophrenia, it is an illness with profound economic impact on patients, their families, and society at large. Although schizophrenia affects only 1% of the population, it accounts for 2.5% of total health care expenditures in the United States.¹⁴ In 1993, treatment of schizophrenia was estimated to total \$40 bil-

lion in direct and indirect treatment costs. It accounts for 10% of all permanent disability and 20% of homelessness in the United States.¹⁵ Davies and colleagues provide an international perspective on the utility of pharmacotherapeutic options in the treatment of schizophrenia.

I trust the readership will find these articles to be of interest and value.

David Alexander Sclar, BPharm, PhD
Section Editor

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