

TO THE EDITOR:

Singletary and colleagues¹ evaluated the impact of a change in first-line therapy for treatment of depression from fluoxetine to sertraline pharmacy department budget costs in the Denver Veterans Affairs Medical Center but failed to assess the cost-effectiveness of the switch.

In decisions about drug coverage and prescribing, health plans and medical care systems should not only consider the safety, effectiveness, and acquisition costs of alternative therapies but also take into account the overall cost of care in relation to health benefit (cost effectiveness). In the absence of a rigorous cost-effectiveness analysis, we open ourselves to formulary decisions that are driven purely by product cost differences and budget-oriented compartmentalization rather than system efficiency or value. It is, therefore, important to re-emphasize that evaluations of drug therapy switches as part of formulary decisions should be subject to cost-effectiveness analyses and not simple cost-cost comparisons or drug utilization reviews.

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1. Singletary T, North DS, Weiss M, et al. A cost-effective approach to the use of selective serotonin reuptake inhibitors in a Veterans Affairs medical center. *Am J Man Care* 1997;3:125-129.

AUTHOR'S REPLY:

Professor Sullivan's comments are well taken with respect to the lack of a pure "cost-effectiveness" form of pharmacoeconomic analysis of our data regarding the recommendation to use sertraline over fluoxetine as a first-line agent for the treatment of depression when a selective serotonin reuptake inhibitor (SSRI) is indicated. We recognize that any in-depth pharmacoeconomic evaluation of drug therapy should include issues such as outcomes or, as Sullivan would express it, the overall cost of care in relation to health benefit.

The Pharmacy and Therapeutics Committee decision to recommend sertraline as a first-line agent was simply that; a recommendation for practitioners to utilize sertraline as the SSRI of first choice when a selective serotonin reuptake inhibitor was indicated. As noted in the paper, we did not encourage "switching" patients from fluoxetine to sertraline in that we recognized that those patients who are clinically stable on fluoxetine, paroxetine, etc., should be considered success stories and certainly not have their therapy tampered with. In the opinion of our Psychiatry Service thought leaders, the data on clinical efficacy, tolerability, side-effects, and long-term out-

comes associated with each of these agents is comparable. This includes issues such as return visits, dose titrations, and overall clinical success with each agent. If one agent might be less expensive to use, we should utilize that agent first. Failure of, or intolerance to that agent would then lead to a trial of the second-line agent.

If indeed a formulary "switch" were to be recommended, an evaluation of the "system efficiency" or "value" of that switch would be appropriate. In that we were recommending which agent to use in a "first-time" SSRI user, we feel that our analysis of the data was sufficient for our stated purposes.

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