New Cancer Drugs at the Cost of Bankruptcy: Will the Oncologist Tell the Patients the Benefit in Terms of Days/Weeks Added to Life?

"All is fine, doctor, chemotherapy for my husband has been planned; however, we are worried how to arrange money for trastuzumab. We have been advised that this drug, if added to chemotherapy, can significantly improve the survival. We have decided to sell our house to get the money," she informed me. I recalled her husband's case: he was suffering from metastatic gastric cancer—image guided cytological examination had confirmed multiple liver metastases. I got worried. Why were they selling their house? What would happen to their children? And what was this significant improvement? I remembered that the well-known Trastuzumab for Gastric Cancer Trial had shown a benefit of 2.7 months in the overall median survival (13.8 months versus 11.1 months; hazard ratio 0.74, 95% confidence interval 0.60–0.91; *p* value .0046) [1]. Do they know this absolute value of the so-called significant improvement in survival? Is this gain of 3 months worth problems that this lady and her children would suffer for a lifetime?

We read with great interest the article titled "Quality of life in the Trasuzumab for Gastric Cancer Trial" by Satoh et al. [2] published in July issue of ***The Oncologist***. The authors have correctly identified the basic panacea of treatment in advanced cancer; gain of a few days or weeks must not be at the cost of deterioration in quality of life. We strongly believe there is another dimension too; the money spent/expended. Is this marginal gain of a few days or weeks worth the money spent? Even in developed countries, cost effectiveness of treatments is being discussed vigorously. The evidence review group report, published in 2011, does not find merit in the efficacy of combination chemotherapy (trastuzumab, cisplatin, capecitabine/fluorouracil) compared with current National Health Service standard therapy for a certain incremental cost-effective ratio based on available literature [3]. Kantarjian et al. [4] raised the issue of the high cost of cancer drugs involved in modest prolongation of progression-free survival in metastatic solid cancers. They supported their argument with an example of anti-vascular endothelial growth factor inhibitors, which provide a median survival advantage of 1.4 months over the standard of care in metastatic colon cancer at a monthly cost of $5,000–$11,000 per month. Is this modest benefit worth of such a high price? The fact that the illness and medical bills contribute to a large and increasing share of bankruptcies in United States of America [5] further highlights the gravity of the situation. The scenario in developing countries gets gloomier as patients suffer out-of-pocket expenditures for cancer care most of the time [6]. It cannot be overemphasized that a high percentage of out-of-pocket payments and low health insurance coverage results in exposure to high financial risk and ultimately pushes the patients and their families into catastrophic poverty [7].

While writing a commentary for the spiraling cost of cancer care, in particular the cost of cancer therapeutics that achieve only marginal benefits, Tito Fojo and Christine Grady raised very pertinent questions [8]: What counts as a benefit in cancer treatment? How much should cost factor into deliberations? Who should decide? The time has come when oncologists need to face these questions and must come out with clear answers. We believe that oncologists must tell each and every patient explicitly the expected benefit of a new cancer treatment modality in terms of "absolute values" (for example, the likely benefit of 2.7 months in the overall median survival if trastuzumab is added to standard chemotherapy [1]). One must not use the statistical jargon—significant improvement in survival—while informing the patient about benefits of a new drug or therapy. And one must allow the patients to make informed decisions without compromising their right to avail the standard therapies or best supportive care.

Pankaj Kumar Garg
Bhupendra Kumar Jain
Department of Surgery, University College of Medical Sciences and Guru Teg Bahadur Hospital, University of Delhi, Delhi, India

Disclosures

The authors indicated no financial relationships.

References

1. Bang YJ, Van Cutsem E, Feyereislova A et al. Trastuzumab in combination with chemotherapy versus chemotherapy alone for treatment of HER2-positive advanced gastric or gastro-oesophageal junction cancer (ToGA): A phase 3, open-label, randomised controlled trial. Lancet 2010;376:687–697.

2. Satoh T, Bang YJ, Gotovkin EA et al. Quality of life in the Trastuzumab for Gastric Cancer Trial. ***The Oncologist*** 2014;19:712–719.

3. Norman G, Rice S, Spackman E et al. Trastuzumab for the treatment of HER2-positive metastatic adenocarcinoma of the stomach or gastro-oesophageal junction. Health Technol Assess 2011;15(suppl 1):33–42.

4. Kantarjian HM, Fojo T, Mathisen M et al. Cancer drugs in the United States: Justum Pretium: The just price. J Clin Oncol 2013;31:3600–3604.

5. Himmelstein DU, Thorne D, Warren E et al. Medical bankruptcy in the United States, 2007: Results of a national study. Am J Med 2009;122:741–746.

6. Pramesh CS, Badwe RA, Borthakur BB et al. Delivery of affordable and equitable cancer care in India. Lancet Oncol 2014;15:e223–e233.

7. Shahrawat R, Rao KD. Insured yet vulnerable: Out-of-pocket payments and India's poor. Health Policy Plan 2012;27:213–221.

8. Fojo T, Grady C. How much is life worth: Cetuximab, non-small cell lung cancer, and the $440 billion question. J Natl Cancer Inst 2009;101:1044–1048.

http://dx.doi.org/10.1634/theoncologist.2014-0263