CORRESPONDENCE

Limiting the accessibility of cost-prohibitive drugs: The story is incomplete

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To the Editor,

The study by Tabing *et al.*¹ makes fascinating, if at times uncomfortable, reading. Nevertheless, further information would enable us to assess the applicability of their identified savings to one's own institution.

For example, what was the proportion of ambulatory cases in this major academic centre? I believe there is a general consensus that isoflurane would be a poor choice of volatile agent in ambulatory patients. Moreover, the authors appropriately acknowledge that their changes in practice which led to an increased use of isoflurane may not be applicable to same-day surgical centres. It would be a shame to lose the advances in anesthesia techniques that have facilitated the tremendous increases in the number of patients undergoing ambulatory surgical procedures in the last 20 years (and the considerably reduced healthcare costs).

Another vital piece of information for us to learn would be the average fresh gas flow rates employed during anesthesia in the authors' institution. Although sevoflurane is cheaper than desflurane at equivalent fresh gas flow rates, fresh gas flow rates of less than 1 L·min⁻¹ can result in desflurane anesthesia being cheaper than sevoflurane anesthesia.²⁻⁴ Perhaps education on the use of low flow techniques would provide significant savings that are comparable to or greater than those achieved in this study. In addition, the use of nitrous oxide is relevant here.

Nitrous oxide can reduce volatile requirements, but many are unaware that nitrous oxide is increasingly expensive. Indeed, the ambulatory centre where I work spends more each year on nitrous oxide than it spends on propofol!

Lastly, I would also be concerned about the law of unintended consequences whereby intervention in a complex system may lead to undesirable outcomes. The authors' reported increased use of naloxone is not a minor concern. The costs - to the hospital and to society overall - from one bad outcome relating to respiratory depression would more than negate any savings in anesthetic drug costs.

Conflicts of interest None declared.

References

1. Tabing AK, Ehrenfeld JM, Wanderer JP. Limiting the accessibility of cost-prohibitive drugs reduces overall anesthetic drug costs: a retrospective before and after analysis. *Can J Anesth* 2015; 62: 1045-54.
2. Weinberg L, Story D, Nam J, McNicol L. Pharmacoeconomics of volatile inhalational anaesthetic agents: an 11-year retrospective analysis. *Anaesth Intensive Care* 2010; 38: 849-54.
3. Golembiewski J. Economic considerations in the use of inhaled anesthetic agents. *Am J Health Syst Pharm* 2010; 67: S9-12.
4. Chernin EL. Pharmacoeconomics of inhaled anesthetic agents: considerations for the pharmacist. *Am J Health Syst Pharm* 2004; 61(Suppl 4): S18-22.

This letter is accompanied by a reply. Please see *Can J Anesth* 2016; 63: this issue.

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