We have assumed that today’s lifestyle entails being subjected to several economic determining factors, but whenever these affect the right of patients to access a drug proven to treat their ailments or the right of ophthalmologists to work in a quiet atmosphere, we believe this to be worthy of some reflection.

Today, ophthalmologists are using a series of medications which, despite the existence of clear scientific evidence pointing at their efficacy to treat certain pathologies, are not available in pharmaceutical specialties authorized for intraocular use. The reason behind this lack of availability seems to be the lack of interest on the part of pharmaceutical laboratories to market this type of medication due to its scarce profitability or, in some cases, because it could compete with certain products which are more profitable. The consequences of this paradoxical and unfair scenario are being suffered both by patients, who have a limited access to an efficient and cheap therapeutic resource for their disease, and by ophthalmologists, who are forced to perform a series of paperwork (authorization requests, signing additional informed consent forms, preparing ophthalmologic reports for each patient, etc.) and even to handle medications on some occasions with the toxicity risk involved in homemade pharmacy or «kitchen pharmacy» according to Anglo-Saxon literature (1), which could be avoided if such medications were available in marketed formats for intraocular use.

We recently mentioned the issues faced by retinal ophthalmologists regarding the use of modern angiogenesis inhibitors and the intravitreous administration of triamcinolone acetonide (2). There is an overwhelming difference in price between bevacizumab (Avastin®) and other angiogenesis inhibitors: pegaptanib (Macugen®) or ranibizumab (Lucentis®) (3). Some ophthalmologists, in order to provide bevacizumab (Avastin®) to patients who due to financial circumstances have no access to other angiogenesis inhibitor therapies, are forced to perform a series of dilutions, decantations and chemical handling necessary to apply the solution destined for systemic use in an intraocular fashion. Economic considerations are very important, but medical and medical-legal criteria must obviously come first. If the patient ended up suffering side effects after a non-authorized medication has been applied, the situation could hardly be sustained.

The Spanish legislation envisions only four ways for administering medications (1), which include:

1. Authorized medications: registered pharmaceutical specialties.
2. Medications under clinical research: in those cases classified as such by the Administration and limited to specific and authorized clinical trials.
3. Foreign medications: all legally marketed medications coming from other countries necessary for a particular case and authorized by the Ministry.
4. Discretionary use medications, prescribed by a hospital’s specialist to a patient whenever no other therapeutic alternatives are available or have been exhausted and their use is deemed necessary.

In the case of bevacizumab (Avastin®), we could not resort to discretionary use. The reason was that...
legal criteria could not be fulfilled (4.) Thus, article 28 of the RD 223/2006 states literally that «...when ever the physician, at his own risk and responsibility, considers it absolutely necessary». We cannot consider the use of this medication «absolutely necessary» if there are therapeutic alternatives available not used so far. Today, there are at least two marketed alternatives to bevacizumab, which are: *pegaptanib* (Macugen®, available today as a registered pharmaceutical specialty in Spain, or *ranibizumab* (Lucentis®), recently approved by the European Medicines Agency, and soon available in our country.

A similar situation affects the intravitreous administration of triamcinolone acetonide (Trigon® Depot) to treat persistent diabetic macular edema and other intraocular inflammatory disorders or subretinal neovascular proliferation.

This use forces ophthalmologists to perform a number of chemical handlings (decantations, screenings…) for the marketed medication. The use of intravitreous triamcinolone is frequent and is warranted by many bibliographical references (5) and clinical trials (6-8.) Nevertheless, since no marketed format is available for intraocular use, it must be used resorting to the discretionary argument (its use is indeed required) or as foreign medication (our references are two marketed medications for intraocular use: Aurocort® from the Indian laboratory Aurolab and Visagen® from the Australian laboratory Regenera.) The use of medications by means of discretionary use entails fulfilling many forms (the ophthalmologist’s report describing previous therapies, the absence of alternative therapies, approval by the hospital’s director, CI document and authorization by the European Medicines Agency). Specialists may request it through the hospital’s pharmacy service for admitted or itinerant patients. If such forms were not fulfilled and complications arose, the ophthalmologist could find himself/herself in a compromised situation.

Lately, surgery on the anterior pole is undergoing a similar situation with the administration of *cefuroxime* in the prophylaxis of infections during intraocular surgery. The findings recently published by the ESCR S (European Society of Cataract and Refractive Surgeons) reveal the risk of endophthalmitis after phacoemulsification decreases by almost five times due to the use of cefuroxime in the anterior chamber at the end of surgery (9.) In view of such clear scientific evidence in a serious procedure, surgical protocols should be logically modified, including the administration of cefuroxime and possibly excluding other types of prophylactic measures whose efficacy has not been proven yet (10.) For the time being, no laboratory manufactures cefuroxime for use in the anterior chamber, and is therefore being administered resorting to the discretionary use of medications, already described. The reason for the lack of a marketed presentation is that this is a generic and cheap medication, and thus laboratories are not interested in performing the complex paperwork needed to obtain authorization for intraocular use (1). This situation means that a cataract surgeon faces a series of difficulties: having to fulfill the forms required, requesting the patient’s signature for two informed consent forms (one related to the surgical procedure and another for the administration of cefuroxime), doing the necessary paperwork with the hospital’s pharmacy services, etc. In the three cases described above, the situation is basically the same: there is a medication whose efficacy has been clearly established by the scientific community, has been systemically used for years, but not authorized for intraocular administration and it is not profitable to market this type of presentation.

We understand that pharmaceutical laboratories are governed by economic criteria, but in the scenarios described above, their lack of commercial interest is suffered by the ophthalmologist and the patients. The ophthalmologist is above all a physician and cannot remain aloof knowing there is an efficient remedy for his/her patient’s ailment; but patients are probably the most affected in such cases. Fortunately, most of them are not aware of the reason why they lack access to an efficient remedy for their disease, which is the lack of profitability for those corporations that manufacture it. The solution to this issue is not easy. This is evidenced by the fact that our colleagues in neighboring countries are dealing with the same issues. It is possible to remedy this situation requesting authorization to the Administration through professional ophthalmologist associations (SEO, SECOIR…) in order to administer these specific substances in an intraocular fashion and to ensure their preparation with the due health guarantees through the hospitals’ pharmaceutical services, as in the case of reinforced eye drops, for example. This could be a good solution for specific medications of proven efficacy in certain therapies and whose manufacture is not profitable for
pharmaceutical laboratories, avoiding the many and repeated paperwork associated with the discretionary use and ophthalmologist’s handling.

Corporations will possibly reject this new administration of medications, not under their control, and will take action to block it or to bring it under their control. In any case, we must denounce this situation and propose a solution which will not force ophthalmologists to assume unnecessary risks from a medical and legal point of view or limit patients’ access to therapeutic resources of proven efficacy for their ailments due to the lack of profitability associated with their manufacture.

REFERENCES

4. Real Decreto 223/2004, de 6 de febrero, por el que se regulan los ensayos clínicos con medicamentos. BOE n.º 33 de 27 de febrero de 2004; 325.