Statin generics: no differences in efficacy after switching

Christoph Baumgärtel, MD

A study presented at the 2010 Congress of the European Society of Cardiology, had created a considerable stir. Its abstract allegedly showed that the originator drug Lipitor was more beneficial than any of its generic statin equivalents. But, in fact the study merely showed that the different potencies of statins were not taken adequately into consideration during the generics switch. The conclusions underscore that statin generics do have essentially the same safety and efficacy as Lipitor and may have implications for new atorvastatin generics that have recently entered the market and will increasingly be prescribed in future.

Keywords: Cardiovascular risk, generics, inferiority, potency, statins

A notable abstract on generics substitution of statins was presented at the 2010 Congress of the European Society of Cardiology [1]. Some of the resulting media coverage was equally interesting, stating, for example, that ‘Patients should stay on Pfizer’s Lipitor, and not switch to generics’ [2]. What the abstract predicted was an increased potential risk for serious cardiovascular events following a switch to generic statins. Despite this interesting finding, the question of whether generic statins should be considered inferior to the atorvastatin brand leader, however, can be answered with a resounding ‘No’.

Nonetheless, what may appear initially to be a paradoxical conclusion makes perfect sense when considering that the study’s aim was not to see if generics act differently in The Netherlands were performed by physicians who were unaware of the different potencies of statins. This occurred after a government-mandated change in policy in which physicians would have to justify their prescriptions of branded statins. The result was an economically beneficial increased switch to generics. At the time of the policy change, however, received less than an equipotent dose of simvastatin after the switch. These figures were calculated under the assumption of a potency ratio of 1:2. If the authors had used a ratio of 1:4, the numbers would have been even higher. Statistical models suggested that this inadequate dosing would lead to a 5.6% increase in LDL-cholesterol levels. This, together with the findings of a meta-regression study [4] showing that every 25 mg/dL (0.65 mmol/L) reduction in LDL-cholesterol lowers the risk of serious cardiovascular events by 14%, indicates that inadequate simvastatin dosing might increase cardiovascular risk by at least 5.5% [1].

It remains uncertain whether these dose reductions were intentional or not. But an intentional dose reduction is unlikely due to the high numbers of patients involved, which does not reflect everyday clinical practice. Worryingly, our conclusion is that a substantial number of switches in The Netherlands were performed by physicians who were unaware of the different potencies of statins. This occurred after a government-mandated change in policy in which physicians would have to justify their prescriptions of branded statins. The result was an economically beneficial increased switch to generics. At the time of the policy change, however,
atorvastatin generics were not yet licensed, and so patients were switched to generic simvastatin instead as the available alternative.

Fortunately, this situation has not occurred in Austria, for example. Here, the guideline for economic prescribing [5] stipulates that in the case of two equally effective treatments the cheaper one should be chosen. To do so, Austrian doctors can access an online ‘Info-tool’ [6] which indicates alternatives to an originator product and their prices. This tool takes the potency difference of statins into account correctly. A search for alternatives to atorvastatin, e.g. to Sortis 20 mg tablets, produces a list of several simvastatin generics, all at an appropriate dosage form of 80 mg tablets, some of them even with a score line. This takes into account dose equivalence in the range of 1:2 to 1:4. The product information leaflets affirm the difference in potency: the indicated dosage of atorvastatin for the prevention of cardiovascular disease is 10 mg per day, while for simvastatin it is 20–40 mg per day.

The Dutch study shows the importance of thoroughly checking product information and using additional info-tools. The erroneous switch to less than equivalent doses of simvastatin, two to four times below the recommended dosage, could have been detected and presumably avoided if the prescribing physicians had consulted these resources properly.

In conclusion, the media coverage that the recommended dosage, could have mistaken prescribed inadequate doses of the generic drug alternatives, putting patients at higher risk of cardiovascular disease.

For patients
A misunderstood study about the statin drug Lipitor and its generic alternatives caused a media storm, with the notion that generics were inferior. A closer examination, however, reveals that physicians had mistakenly prescribed inadequate doses of the generic drug alternatives, putting patients at higher risk of cardiovascular disease.

Competing interests: None.

Provenance and peer review: Commissioned; externally peer reviewed.

References