WHAT'S HAPPENING IN

Neurology® Clinical Practice

Neurology.org/CP

Abstracts

Articles appearing in the April 2018 issue

Uncertainties from a worldwide survey on antiepileptic drug withdrawal after seizure remission

Background We sought to determine differences in practice for discontinuation of antiepileptic drugs (AEDs) after seizure remission and stimulate the planning and conduction of withdrawal trials.

Methods We utilized a worldwide electronic survey that included questions about AED discontinuation for 3 paradigmatic cases in remission: (1) focal epilepsy of unknown etiology, (2) temporal lobe epilepsy after surgery, and (3) juvenile myoclonic epilepsy. We analyzed 466 complete questionnaires from 53 countries, including the United States. Statistical analysis included χ^2 and multivariate logistic regression.

Results Case 1: responders in practice for <10 years were less likely to taper AEDs: odds ratio (OR) (95% confidence interval [CI]) 0.52 (0.32–0.85), $p = 0.02$. The likelihood of stopping AEDs was higher among doctors treating children: OR (95% CI): 11.41 (2.51–40.13), $p = 0.002$. Doctors treating children were also more likely to stop after 2 years or less of remission: OR (95% CI): 6.91 (2.62–19.31), $p = 0.002$, and the same was observed for US physicians: OR (95% CI): 1.61 (1.01–2.57), $p = 0.0049$. Case 2: responders treating children were more likely to taper after 1 year or less of postoperative remission, with the goal of discontinuing all medications: OR (95% CI): 1.91 (1.09–3.12), $p = 0.015$, and so were US-based responders: OR (95% CI): 1.73 (1.21–2.41), $p = 0.003$. Case 3: epileptologists were less likely to withdraw the medication: OR (95% CI): 0.56 (0.39–0.82), $p = 0.003$, and so were those in practice for 10 or more years: OR (95% CI): 0.54 (0.31–0.95), $p = 0.025$.

Conclusions We observed several differences in practice for AED withdrawal after seizure remission that highlight global uncertainty. Trials of AED discontinuation are needed to provide evidence-based guidance.

NPub.org/NCP/9102a

Achieving high-value care for all and the perverse incentives of 340B price agreements

Section 340B of the Public Health Service Act requires drug manufacturers to enter into price agreements with the Department of Health and Human Services. These agreements result in variation in the price paid to acquire a drug by sector, which complicates the price used in cost-effectiveness analyses. We describe the transactions and sectors in a 340B agreement using a multiple sclerosis drug. Cost-effectiveness estimates were calculated for the drug using drug prices from the manufacturer and payer perspective. We found the amount paid to the manufacturer (340B price) was a good value ($118,256 per quality-adjusted life-year); however, from the payer drug cost perspective, good value ($196,683 per quality-adjusted life-year) was not achieved. Given that emerging value frameworks incorporate cost-effectiveness, these price variations may have downstream negative consequences, including inaccurate coverage and reimbursement policy recommendations. Upcoming policy changes to the 340B program should incentivize pricing schemes hinged on transparency and value.

NPub.org/NCP/9102b

Editorial

NPub.org/NCP/9102c

Practice Current

Our survey on the topic "When do you suspect autoimmune encephalitis and what is the role of antibody testing?" has received over 1,000 responses from over 80 countries. Explore this topic and others on our redesigned website: compare your practice with peers and see survey results displayed on an interactive world map.

NPub.org/NCP/pc6

