40 YEARS PUBLIC CITIZEN Health Letter

SIDNEY M. WOLFE, M.D., EDITOR DECEMBER 2011 – VOL. 27, No. 12

Doctor Experience Linked With Risk of Death From Carotid Artery Stenting Procedures

A recent *Journal of the American Medical Association (JAMA)* study suggests that older patients undergoing a procedure to place a stent in narrowed carotid arteries are more likely to die within 30 days after the procedure when it is performed by less experienced physicians. This finding is not surprising and is quite consistent with the results of prior studies that have assessed the relationship between the experience level of doctors performing surgery or other invasive procedures and the complications that occur in patients following such procedures. In other words, as a general rule, less experience equals more complications.

Risk of Death Within 30 Days of Undergoing Carotid Artery Stenting in Medicare Beneficiaries, Based on Physician Experience With the Procedure

Risk According to Physician's Annual Volume of Procedures		
Annual Physician Volume (# of procedures per year)	**30-Day Mortality Rate**	**Relative Odds of Patients Dying Compared to High-Volume Group**
High (≥24 per year)	1.4%	--
Medium (12-23 per year)	1.6%	0.8- to 1.7-fold
Low (6-11 per year)	1.9%	1.0- to 2.0-fold
Very low (<6 per year)	2.5%	1.4- to 2.7-fold
Risk According to Total Number of Procedures Performed by the Physician		
Total Physician Experience	**30-Day Mortality Rate**	**Odds of Patients Dying Compared to Late Operator Experience**
Late (12th or later procedures)	1.4%	--
Early (1st to 11th procedures)	2.3%	1.2- to 2.4-fold

Carotid artery narrowing and stenting procedures

As people age, they commonly develop atherosclerosis, a disorder that causes gradual narrowing of the arteries supplying blood and oxygen to the heart, brain, kidneys, limbs and other organs. Such narrowing occurs because plaque — composed of cholesterol, fat and calcium — builds up along the inner lining of arteries. Major risk factors for the development of atherosclerosis include hypertension, diabetes, high cholesterol, smoking and certain hereditary factors.

The carotid arteries are the major arteries in the neck that supply blood to the brain. Patients who develop severe narrowing of these arteries due to atherosclerosis are at increased risk for strokes, which can cause severe brain injury and death. Approximately 10-15 percent of strokes are caused by atherosclerosis of the carotid arteries. For many patients, the development of a stroke is preceded by a transient ischemic attack (TIA). A TIA, sometimes called a mini-stroke, causes temporary neurologic symptoms (such as numbness or weakness in an arm or leg, or visual or speech difficulties) that last for several minutes and then completely resolve.

For most patients with atherosclerotic narrowing of the carotid arteries, the primary treatments are smoking cessation — if the patient smokes — and medical therapy with drugs to treat hypertension, diabetes and high cholesterol. Such patients also are frequently treated with antiplatelet drugs, such as aspirin, which help to prevent platelets in the bloodstream from sticking to one another and forming a clot that could cause a stroke (by blocking a carotid artery at the site of a plaque buildup or by moving downstream and blocking one of the smaller arteries branching off of the carotid arteries).

For some patients with severe degrees of carotid artery narrowing, doctors recommend a surgical procedure called a carotid endarterectomy to remove the plaque buildup from the inside of the carotid artery and restore normal blood flow to the brain. However, a carotid

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endarterectomy is a major surgical procedure that poses significant risks to the patient, including the risk of stroke and death.

Over the past decade, a less invasive procedure involving placement of a stent in the carotid arteries has been developed as an alternative to carotid endarterectomy surgery. These stenting procedures, typically performed (using various types of stents) by neurosurgeons, vascular surgeons, cardiologists or interventional radiologists, involve inserting a long catheter into an artery in the groin or arm and, guided by X-ray imaging, advancing the tip of the catheter to the portion of the carotid artery that is severely narrowed. The tip of the catheter has a small balloon over which a stent, an expandable tube made of metal mesh, has been placed. When the balloon is blown up at the site of the carotid artery narrowing, the stent expands and props open the narrowed artery.

JAMA study overview

Dr. Brahmajee Nallamothu and his co-authors analyzed the Centers for Medicare and Medicaid Services records for Medicare beneficiaries aged 65 years or older who underwent a carotid artery stenting procedure between Jan. 1, 2005, and Dec. 31, 2007. They identified 24,701 patients who underwent this procedure, performed by 2,339 physicians during the three-year study period. The average age of the patients in the study was 76.2 years. Forty percent of the patients were women.

The researchers used two measures to assess physician experience with carotid stenting. The first measure was the annual number of stent procedures performed by the physician. For this measure, physicians were divided into the following four categories: fewer than 6 (very low volume), 6-11 (low volume), 12-23 (medium volume) and 24 or more (high volume) procedures per year.

The second measure of physician experience was the physician's total actual experience with carotid artery stenting at the time of a particular stenting procedure. For this measure, the stenting procedures were divided into the following two categories: early procedures (surgeries one through 11 performed on a Medicare beneficiary by a particular physician) and late procedures (surgeries 12 and beyond performed on a Medicare beneficiary by a particular physician).

The primary outcome measure that the researchers were interested in was 30-day mortality following the stenting procedure. In assessing the effect of physician experience, as opposed to patient characteristics, on post-procedure mortality rates, the researchers adjusted for differences in patient age, sex, race and medical-problem severity.

Study results: lower experience associated with a higher mortality rate

Overall, 451 patients (1.9 percent) died within 30 days of undergoing the carotid artery stenting procedure.

For patients undergoing carotid artery stenting procedures, the 30-day mortality was highest (2.5 percent) when the procedure was performed by physicians who did fewer than six surgeries per year and lowest (1.4 percent) when performed by physicians who did 24 or more surgeries per year. After adjusting for numerous risk factors that could have affected the mortality rates, the researchers found that compared to patients undergoing stenting procedures by physicians with the most experience, patients undergoing procedures by the physicians with the least experience had a 1.4- to 2.7-fold higher 30-day mortality rate.

Of note, Nallamothu and his colleagues found that fewer than 1 in 8 physicians in the study had an annual carotid stenting procedure volume of at least 12 procedures per year during the

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three-year study period. Thus, only a small minority of physicians performed a medium to high volume of these procedures.

Similarly, lower physician experience at the time of a particular carotid stenting procedure was associated with a higher mortality rate. Patients treated during the early phase of a physician's experience with carotid stenting (first through 11th procedures) had a 30-day mortality rate of 2.3 percent, whereas patients treated during the late phase of a physician's experience with this procedure had a 30-day mortality of 1.4 percent. After again adjusting for numerous risk factors, the researchers found that compared to patients undergoing a physician's 12th or later carotid stenting procedure, patients undergoing a physician's first through 11th procedure had a 1.2- to 2.4-fold greater 30-day mortality rate.

Implications of the *JAMA* study results

Carotid artery stenting was first approved by the Food and Drug Administration (FDA) in 2004 for patients whose risk to undergo carotid endarterectomy surgery is too high because of their overall health status and factors related to the anatomy of the narrowing in the carotid artery. In May 2011, the FDA expanded the approved indications for carotid artery stenting to all patients with significant carotid artery narrowing, not just those at high surgical risk from carotid endarterectomy surgery.

Both carotid artery endarterectomy and carotid artery stenting procedures carry short-term risks of stroke and death during the first month after undergoing the procedure. These procedures are done despite the short-term risks because they appear to lower the long-term risk of suffering a stroke in patients with severe carotid artery narrowing, particularly for those patients who have had a stroke or TIA in the preceding six to 12 months.

However, in order for carotid artery stenting procedures to achieve overall benefits in the long term, the short-term risks of death, stroke and other serious complications must be sufficiently low.

In a *JAMA* editorial commenting on the study by Dr. Nallamothu and his colleagues, Dr. Ethan Halm expressed concern that the Medicare beneficiaries in the study experienced a high overall 30-day mortality rate of 1.9 percent.

Dr. Halm pointed out that this death rate was more than twice that seen in a recently completed randomized study — known as the CREST trial — comparing carotid stenting with carotid endarterectomy for patients with symptomatic and asymptomatic carotid artery atherosclerosis (0.7 percent) and exceeded the mortality rates seen in several other studies conducted following FDA approval of carotid artery stenting (0.9-1.1 percent). The mortality rate among even the most experienced physicians in the *JAMA* study was substantially higher than those seen in these other studies.

Dr. Halm suggested that such relatively high complications in real-world practice would significantly reduce, and perhaps eliminate, the overall long-term benefits of carotid artery stenting, especially for those patients who have no symptoms and have much less to gain from such procedures.

Because the experience of the physician performing these procedures plays a major role in determining the short-term risks of the procedure, patients who may be candidates for carotid artery stenting should seek out or be referred to physicians who have the most experience performing it.

Suggestions for patients

Because the experience of the physician performing these procedures plays a major role in determining the short-term risks of the procedure, patients who may be candidates for carotid artery stenting should seek out or be referred to physicians who have the most experience performing it.

If a physician recommends that you or a loved one undergo carotid artery stenting, you should first consider obtaining a second opinion about whether such a procedure is likely to provide significant potential benefits that outweigh the short-term risks of stroke and death.

If you decide to consent to carotid artery stenting, you should ask the doctor to whom you have been referred how many times have they performed the procedure; how many times a year, in the most recent year, have they performed the procedure; who else (other physicians) will be involved in the procedure; and what were the rates of death, stroke and other serious complications during the 30-day period following the procedure for the patients who have undergone surgeries under the recommended doctor. If the physician reports a low level of experience or a high rate of death and serious complications, or is unable to provide these statistics, you should seek another physician to perform the procedure.

If you or a loved one dies or has a stroke or other serious adverse event following a carotid artery stenting procedure, you should report it to the FDA MedWatch Adverse Event Reporting program online or by regular mail, fax or phone.

- **Online:** https://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm
- **Regular mail:** Use postage-paid, pre-addressed FDA form 3500 and mail to MedWatch, 5600 Fishers Lane, Rockville, MD 20852-9787
- **Fax:** (800) FDA-0178
- **Phone:** (800) FDA-1088 ✦

Medical-Device Approval Process Flawed and Dangerous for Patients

The Institute of Medicine (IOM), a part of the prestigious National Academy of Sciences, has found — and stated in its June 29, 2011, report — that the Food and Drug Administration's (FDA) 510(k) process for approving medical devices is so unreliable it should be scrapped and replaced. The process, used to evaluate 99 percent of medical devices for market approval, is rife with loopholes, making it a favorite avenue for manufacturers and a threat to patient safety.

The FDA requested the IOM report, which focused on use of the 510(k) process for moderate-risk devices. In addition to the above-stated finding and remedy, the IOM also suggested the FDA create a method to track the performance of devices once approved, as well as a way to quickly stop sales if there appears to be a safety issue.

FDA regulation of medical devices

Device law is a relatively new mechanism. Initially, there was no FDA approval required for the marketing of medical devices. Then, in 1976, as a result of the deaths and infertility caused by the Dalkon Shield and other intrauterine devices (a form of birth control), Congress granted the FDA authority to do so. (As was the case with the prescription-drug industry, it took a tragedy to push forward regulations regarding medical-device safety and effectiveness.)

Medical devices are classified by the FDA into three categories based on the level of risk posed to patients. Class I devices are the lowest risk (e.g., tongue depressors, bandages and crutches). Class II includes intermediate-risk devices (e.g., artificial hips, external heart defibrillators, electrocardiographs, contact lens solutions, hearing aids and drills for orthopedic applications). Class III devices are of the greatest potential risk (e.g., implantable pacemakers, HIV diagnostic tests and heart valves).

As was the case with the prescription-drug industry, it took a tragedy to push forward regulations regarding medical-device safety and effectiveness.

The device law has two parts that regulate approval: The first, premarket approval (PMA), requires extensive testing to ensure that devices are safe and effective (for high-risk devices). The second, the so-called 510(k) process, is used for approval of newer versions of existing products (intended for low- and moderate-risk devices).

Inadequacy of the 510(k) process

Unfortunately, device law allows some moderate-risk devices, such as hip replacements, to be approved without any clinical testing. The 510(k) process is clearly preferred by manufacturers, as it requires neither clinical trials nor manufacturing inspections. Manufacturers only have to convince the FDA that the device is "substantially equivalent in material, purpose, and mechanism of action to another device that was already on the market in May 1976."

The FDA unfortunately uses the 510(k) process for intermediate-risk devices, in part because it lacks the resources to handle the more complex PMA approval process and in part because of industry pressure to get devices to market quickly.

The inadequacy of the 510(k) process has had serious consequences, evidenced in the recent case of a faulty metal-on-metal hips device that left patients requiring additional painful operations and, in some cases, suffering damage to bone, muscles and nerves from shed metallic particles.

In 2002, a new law, the Medical Device User Fee and Modernization Act, went into effect. In an era of deregulation, this act was interpreted by the FDA in the least burdensome way. "Substantially equivalent" devices came to include even products that were made from different materials and that worked in different ways. Furthermore, approval could be based solely on biomaterials testing (e.g., testing the strength of a part of the device in the lab), not on clinical trials. Previously approved devices (to which substantially equivalent devices were compared) were not limited to the devices on the market in 1976, but could include any device subsequently cleared by either process. This means that the product being evaluated for approval could be very different from the originally approved device.

With such slack standards, the 510(k) process has been used to evaluate 99 percent of all devices for approval, with only 1 percent undergoing the more rigorous clinical testing of the PMA process.

Infuse device: an example of 510(k) dangers

As device law is currently applied (and as noted by IOM), it is very lax and can put patients at risk.

Another recent example of the serious consequences arising from reliance on the 510(k) process is the use of a bone growth protein (BMP) marketed as Infuse. Infuse was approved in 2002 for use in fusions of the lumbar spine to reduce back pain. It went through the 510(k) process because it was said to be similar to a previously approved BMP device. The FDA limited Infuse's approval to a specific dose and a specific section of the spine. However, after thirteen medical journal articles stated that there were no adverse effects of

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Infuse in patients, its use soared not only for its approved use, but also for unapproved uses and unapproved doses.

What was hidden from doctors and patients was the fact that, in reality, there had been many serious adverse effects with Infuse, including increased wound infections, bony overgrowth in the spinal canal, bone loss and male sterility. Finally, the FDA, on July 1, 2008, issued an alert for life-threatening complications related to the BMP's use in the cervical spine, leading to difficulty swallowing, breathing and speaking.

It has since been discovered that the investigators in the Infuse clinical trials, who said there were no adverse effects, had been paid millions of dollars by the manufacturer. In June 2011, *The Spine Journal* dedicated its whole issue to articles that challenged the earlier published research on Infuse safety.

Pressure to weaken further regulation of medical devices

Even though only 1 percent of devices have had to withstand the rigors of the clinical trial PMA process, there are pressures to limit further the FDA's ability to request safety and effectiveness data from device manufacturers. One example is Senate Bill 1700, introduced by Amy Klobuchar — from Minnesota, home of six Medtronics (a medical device manufacturer) facilities — along with Sens. Richard Burr and Michael Bennet. This bill is written in such a way as to weaken further the medical-device approval process. As shown below, the wording is so vague that if it becomes law, the FDA will be handcuffed in its ability to request almost anything regarding efficacy or safety data from manufacturers.

- The FDA cannot "request information unrelated or irrelevant to a demonstration of reasonable assurance of device safety and effectiveness." Who gets to decide whether what FDA scientists need is "unrelated or irrelevant"? Undoubtedly, it will be the industry.
- The FDA is also supposed to see whether "pre-clinical data, such as well-designed bench or animal testing" is adequate for approval. Can one adequately test a hip replacement in an animal model or on a workbench?
- "If clinical data are needed," the device makers "shall utilize ... alternatives to randomized, controlled clinical trials, such as the use of surrogate endpoints." The usual meaning of surrogate endpoints is something that one uses to measure the effectiveness of a clinical trial. Here, what method could scientists use besides a clinical trial to test an artificial hip? And who decides if the endpoint is valid?
- The FDA would also be required to adhere to a series of vague rules, such as "[it] shall not request or accept information unrelated or irrelevant to the substantial equivalence evaluation." If industry submits information, who decides whether the information is irrelevant? How would the FDA be kept from accepting it? Would the industry decide to withdraw it?
- The FDA "shall not evaluate issues that do not present a major impact on the intended use." Again, who decides whether an issue has a major impact? If it is industry, the FDA turns into a rubber-stamp agency.
- Furthermore, the directives that the FDA "shall use all reasonable mechanisms to lessen review times and render regulatory decisions," and that the secretary of Health and Human Services is to conduct "an extensive review of the management and regulatory processes at the FDA's Center for Devices and Radiological Health ... to ensure any actions carried out ... take into consideration the potential impacts on innovation" are final big pushes to ensure devices get approved quickly and without troublesome requirements related to safety and effectiveness.

These are all items guaranteed to provoke arguments sure to be won by industry, with Congress behind it, unless there is a popular uproar against such dangerous legislative weakening of the FDA's authority.

FDA should heed IOM recommendations

On Sept. 2, 2011, Public Citizen sent a letter to the FDA endorsing the IOM report, encouraging the FDA to follow IOM's recommendations and stressing that, before submission for approval, manufacturers of moderate- and high-risk devices should be required to conduct clinical trials to show that the device was both safe and effective. We have long been concerned about the weaknesses of the 510(k) process. In September 2005, we petitioned the FDA concerning defective heart defibrillators approved under this process.

Now, in 2011, the Medical Device User Fee Act is up for renewal. This act sets the fees charged to the medical-device industry for each submission to the FDA to review a device. Congress is holding hearings, and in October alone, lawmakers introduced 10 bills in the House and one in the Senate. The groups testifying before Congress on these bills are those most interested in profits, such as venture capitalists, entrepreneurs and trade groups, as well as some patients testifying on the side of industry, claiming that delays in approval had caused them harm. Patients who actually have been harmed have not, as of now, been asked to testify.

In many other countries, the medical-device industry is required to keep a registry to track device failures. Yet in the U.S., industry and its allies want nothing to do with strengthening device regulation and began even before the release of the IOM report to do everything in their power to discredit it. Things do not look promising for consumers. ✦

Product Recalls

November 1, 2011 – November 16, 2011

This section includes recalls from the Food and Drug Administration (FDA) Enforcement Report for drugs and dietary supplements (www.fda.gov/Safety/Recalls/EnforcementReports/default.htm), and Consumer Product Safety Commission (CPSC) recalls of consumer products.

DRUGS AND DIETARY SUPPLEMENTS

Recalls and Field Corrections: Drugs – Class I

Indicates a problem that may cause serious injury or death

Slim Forte Slimming Capsule, 30-capsule box. Volume of product in commerce: Unknown. FDA laboratory analyses found the products to contain sibutramine, an appetite suppressant that was withdrawn from the market in October 2010 for safety reasons, making these products unapproved new drugs. Lot #s: 20100604, expiration date 06/03/2012; 20100928, expiration date 09/27/2012. Intercharm Inc.

Meizitang Botanical Slimming 100% Natural Soft Gel, 650 mg, 3 x 12-count capsules per blister package. Volume of product in commerce: Unknown. FDA laboratory analyses found the products to contain sibutramine, an appetite suppressant that was withdrawn from the market in October 2010 for safety reasons, making these products unapproved new drugs. Expiration date 12/23/2011. Intercharm Inc.

Recalls and Field Corrections: Drugs – Class II

Indicates a problem that may cause temporary or reversible health effects; unlikely to cause serious injury or death

The following drugs and supplements were recalled for penicillin cross-contamination: There is potential for beta-lactam cross-contamination of nonpenicillin drug products repackaged in the same facility. Volume of product in commerce: Unknown. Lot #s: Multiple lots affected. Contact your pharmacist. Aidapak Services, LLC.

Abacavir/Lamivudine, 600/300-mg tablets.

Abacavir/Lamivudine/Zidovudine, 300/150/300-mg tablets.

Abacavir Sulfate, 300-mg tablets.

Acamprosate Calcium DR, 333-mg tablets.

Acarbose, 25- and 100-mg tablets.

Acebutolol HCL, 200-mg caplets.

Acetaminophen, 80-mg chewable tablets.

Acetaminophen, 80-mg rapid tablets.

Acetaminophen, 325- and 500-mg tablets.

Acetaminophen/ASP/Caffeine, 250/250/65-mg tablets.

Acetaminophen/Codeine, 300/30-mg tablets.

Acetaminophen/Diphenhydramine HCL, 500/25-mg tablets.

Acetaminophen ER/8 Hour, 650-mg tablets.

Acetaminophen ER/Arthritis, 650-mg tablets.

Acetazolamide, 125- and 250-mg tablets.

Acetazolamide ER, 500-mg caplets.

Acyclovir, 200-, 400- and 800-mg caplets.

Adefovir Dipivoxil, 10-mg tablets.

Albuterol, 2-mg tablets.

Albuterol Sulfate Extended-Release, 4-mg tablets.

Alendronate Sodium, 5-, 35- and 70-mg tablets.

Alfuzosin HCL ER, 10-mg tablets.

Aliskiren, 150- and 300-mg tablets.

Alprazolam, 0.5-mg tablets.

Aluminum Hydroxide/Magnesium Carbonate, 160/105-mg chewable tablets.

Aluminum Hydroxide/Magnesium Trisilicate, 80/14.2-mg chewable tablets.

Amantadine HCL, 100-mg caplets.

Amiloride HCL, 5-mg tablets.

Amiloride HCL /Hydrochlorothiazide, 5/50 mg.

Amitriptyline HCL, 10-, 75-, 100- and 150-mg tablets.

Amlodipine Besylate, 5- and 10-mg tablets.

Amoxapine, 25-mg tablets.

Amoxicillin, 250-, 500- and 875-mg caplets.

Amoxicillin/Clavulanate Potassium, 250/125-mg, 500/125-mg and 875/125-mg tablets.

Amoxicillin/Clavulanate Potassium ER, 1,000/62.5-mg tablets.

Ampicillin, 250-mg caplets.

Anagrelide HCL, 0.5-mg caplets.

Anastrozole, 1-mg tablets.

DRUGS AND DIETARY SUPPLEMENTS (continued)

Aprepitant, 80-mg caplets.

Aripiprazole, 2-, 5-, 10- and 15-mg tablets.

Armour Thyroid 1/2 Grain, 30-mg tablets.

Ascorbic Acid, 250- and 500-mg chewable tablets and 250-mg tablets.

Aspirin, 325-mg tablets.

Aspirin Buffered, 325-mg tablets.

Aspirin Chewable, 81-mg tablets.

Aspirin EC, 81-, 162- and 325-mg tablets.

Aspirin ER Dipyridamole, 25/200-mg caplets.

Atazanavir Sulfate, 150- and 300-mg caplets.

Atenolol, 25-mg tablets.

Atomoxetine HCL, 10-, 18-, 25-, 40-, 60-, 80- and 100-mg caplets.

Atorvastatin Calcium, 10- and 80-mg tablets.

Azathioprine, 50- and 100-mg tablets.

Azithromycin, 500- and 600-mg tablets.

Baclofen, 10- and 20-mg tablets.

Balsalazide Disodium, 750-mg caplets.

Benazepril HCL, 5- and 40-mg tablets.

Benzonatate, 100-mg caplets.

Benzonatate Soft Gel Caps, 100-mg caplets.

Benztropine Mesylate, 0.5-, 1- and 2-mg tablets.

Bethanechol Chloride, 5-mg tablets.

Bicalutamide, 50-mg tablets.

Bismuth Subsalicylate, 262-mg chewable tablets.

Bisoprolol Fumarate, 5-mg tablets.

Bisoprolol Fumarate/HCTZ, 2.5/6.25-mg, 5/6.25-mg and 10/6.25-mg tablets.

Bromocriptine Mesylate, 2.5-mg tablets.

Budeprion HCL ER, 100-mg tablets.

Budesonide, 3-mg caplets.

Bumetanide, 0.5-mg tablets.

Buprenorphine HCL SL, 2-mg tablets.

Buprenorphine/Naloxone SL, 0.5-mg and 8/2-mg tablets.

Buprenorphine SL, 8-mg tablets.

Bupropion HCL, 100- and 150-mg tablets.

Bupropion HCL ER, 100-, 150-, 200- and 300-mg tablets.

Buspirone HCL, 10-mg tablets.

Butalbital/APAP/Caffeine, 325/50/40-mg and 50/325/40-mg.

Butalbital/APAP/Caffeine/Codeine Phosphate, 30/50/40/325-mg and 50/325/40/30-mg.

Caffeine, 200-mg caplets.

Calcitriol, 0.25- and 0.5-mcg caplets.

Calcium Acetate, 667-mg caplets.

Calcium Carbonate, 500- and 750-mg chewable tablets and 600- and 648-mg tablets.

Calcium Carbonate/DHEA, 25-mg tablets.

Calcium Carbonate-Glycine Chew Tab, 420-mg tablets.

Calcium Carbonate Plus D, 500-mg/400-IU chewable tablet and 600-mg/400-IU tablets.

Calcium Citrate, 200-mg tablets.

Calcium Citrate Plus D3, 200-mg/250-IU, 315-mg/200-IU and 315-mg/250-IU tablets.

Calcium Gluconate, 500- and 648-mg tablets.

Calcium Polycarbophil, 625-mg tablets.

Candesartan Cilexetil, 4- and 8-mg tablets.

Capecitabine, 150- and 500-mg tablets.

Captopril, 12.5-mg tablets.

Carbamazepine, 100- and 200-mg chewable tablets.

Carbamazepine ER, 100-, 200-, 300- and 400-mg tablets.

Carbidopa, 25-mg tablets.

Carbidopa/Levodopa, 25/100-mg tablets.

Carbidopa/Levodopa ER, 25/100-mg tablets.

Carbidopa/Levodopa ODT, 25/250-mg tablets.

Carvedilol, 3.125- and 6.25-mg tablets.

Carvedilol ER, 80-mg caplets.

Carvedilol Phosphate ER, 10-, 20- and 40-mg caplets.

Cefdinir, 300-mg caplets.

Cefpodoxime Proxetil, 100-mg tablets.

Cefuroxime Axetil, 250- and 500-mg tablets.

Cephalexin, 250- and 500-mg caplets.

Cetirizine HCL, 10-mg tablets.

Chlorophyll, 3-mg tablets.

Chlorophyllin Copper Complex, 100-mg tablets.

Chloroquine Phosphate, 250-mg tablets.

Chlorothiazide, 250-mg tablets.

Chlorpromazine HCL, 10-mg tablets.

Chlorpropamide, 250-mg tablets.

Chlorzoxazone, 500-mg tablets.

Cholecalciferol/Calcium, 1,000-IU/185-mg, 2,000-IU/180-mg and 5,000-IU/180-mg tablets.

Cholecalciferol/Calcium/Phosphorus, 120-IU/105-mg/81-mg tablets.

Cholecalciferol D3-50, 50,000-IU caplets.

Cilostazol, 50- and 100-mg tablets.

Cinacalcet HCL, 30-mg tablets.

Ciprofloxacin, 250- and 500-mg tablets.

DRUGS AND DIETARY SUPPLEMENTS (continued)

Citalopram, 20-mg tablets.
Citicoline Sodium, 500-mg tablets.
Clarithromycin, 250- and 500-mg tablets.
Clindamycin HCL, 150- and 300-mg caplets.
Clomipramine HCL, 25- and 50-mg caplets.
Clonazepam, 0.5-mg tablets.
Clonidine HCL, 0.1- and 0.2-mg tablets.
Clorazepate Dipotassium, 3.75- and 7.5-mg tablets.
Clozapine, 25- and 200-mg tablets.
Coenzyme Q-10, 30-, 50- and 100-mg softgels.
Colchicine, 0.6-mg tablets.
Colesevelam HCL, 625-mg tablets.
Conjugated Estrogens, 0.3-, 0.625-, 0.9- and 1.25-mg tablets.
Conjugated Estrogens/Medroxyprogesterone Acetate, 0.625/2.5-mg tablets.
Cortef, 10-mg tablets.
Cortisone Acetate, 25-mg tablets.
Coumadin, 1-mg tablets.
Covaryx, 1.25/2.5-mg.
Cranberry Concentrate, 450-mg caplets.
Cranberry Extract, 200-mg caplets.
Cranberry Fruit, 475-mg caplets.
Cyanocobalamin, 100-, 250-, 500- and 1,000-mcg tablets.
Cyclobenzaprine, 5-mg tablets.
Cyclobenzaprine HCL, 10-mg tablets.
Cyclophosphamide, 25- and 50-mg tablets.
Cyproheptadine HCL, 4-mg tablets.
Cytomel, 5-mcg tablets.
Quetiapine Fumarate, 25-, 100- and 300-mg tablets.
Quinapril HCL, 5-, 10-, 20- and 40-mg tablets.
Quinidine Sulfate, 200, 300- and 325-mg tablets.
Raloxifene HCL, 60-mg tablets.
Raltegravir, 400-mg tablets.
Ramipril, 10-mg.
Ranexa, 500-mg tablets.
Ranitidine, 75- and 150-mg tablets.
Ranolazine ER, 500-mg tablets.
Rasagiline, 0.5- and 1-mg tablets.
Rena-Vite and Rena-Vite RX tablets.
Repaglinide, 0.5-, 1- and 2-mg tablets.
Reserpine, 800-mg tablets.
Reyataz, 100-mg caplets.
Ribavirin, 200-mg tablets.
Riboflavin, 100-mg tablets.
Rifabutin, 150-mg caplets.
Rifampin, 150- and 300-mg caplets.
Rifaximin, 200-mg tablets.
Riluzole, 50-mg tablets.
Rimantadine HCL, 100-mg tablets.
Risedronate Sodium, 5-, 30- and 35-mg tablets.

DRUGS AND DIETARY SUPPLEMENTS (continued)

Risperidone, 1-, 2-, 3- and 4-mg tablets.
Ritonavir, 100-mg caplet and 100-mg tablets.
Rivastigmine Tartrate, 4.5-mg caplets.
Ropinirole HCl, 0.25-, 0.5-, 1- and 2-mg tablets.
Rosiglitazone Maleate, 2- and 4-mg tablets.
Rosuvastatin Calcium, 5- and 10-mg tablets.
Saccharomyces Boulardll LYO, 250-mg caplets.
Salsalate, 500- and 750-mg tablets.
Saquinavir Mesylate, 200-mg caplets.
Selenium, 100- and 200-mcg tablets.
Selegiline HCL, 5-mg caplets.
Sennosides, 8.6-mg tablets.
Sennosides/Docusate Sodium, 8.6/50-mg tablets.
Sertraline HCL, 100-mg tablets.
Sevelamer Carbonate, 800-mg tablets.
Sevelamer HCL, 400- and 800-mg tablets.
Sildenafil, 20-mg tablets.
Sildenafil Citrate, 25- and 50-mg tablets.
Simvastatin, 10-, 20-, 40- and 80-mg tablets.
Sitagliptin, 25-, 50- and 100-mg tablets.
Sodium Bicarbonate, 325- and 650-mg tablets.
Sodium Chloride, 1-g tablets.
Sodium Fluoride, 0.5- and 1-mg chewable tablets.
Solifenacin Succinate, 5-mg tablets.
Sotalol HCL, 80- and 120-mg tablets.
Spironolactone, 25-mg tablets.
Stavudine, 20- and 40-mg caplets.
Sucralfate, 1-g tablets.
Sular, 25.5-mg tablets.
Sulfadiazine, 500-mg tablets.
Sulfamethoxazole/Trimethoprim, 400/80-mg tablets.
Sulfamethoxazole/Trimethoprim DS, 800/160-mg and 400/80-mg tablets.
Sulfasalazine, 500-mg tablets.
Sulindac, 150- and 200-mg tablets.
Sumatriptan Succinate, 25-mg tablets.
Sunitinib Malate, 12.5- and 25-mg caplets.
Tacrolimus, 0.5- and 1-mg caplets.
Tamoxifen Citrate, 10- and 20-mg tablets.
Tamsulosin Hydrochloride, 0.4-mg caplets.
Temazepam, 7.5-mg caplets.
Temozolomide, 5-, 20-, 100- and 250-mg caplets.
Tenofovir Disoproxil Fumarate, 300-mg tablets.
Terazosin HCL, 2-mg caplets.
Terbinafine HCL, 250-mg tablets.
Terbutaline Sulfate, 2.5- and 5-mg tablets.
Tetracycline HCL, 500-mg caplets.
Theophylline Anhydrous ER, 100-, 200-, 300- and 400-mg caplets.
Theophylline ER, 100-, 400- and 450-mg tablets.
Thiamine, 100-mg tablets.
Thiamine Hydrochloride, 50-mg tablets.
Thioridazine HCL, 10- and 50-mg tablets.
Thiothixene, 1-, 2-, 5-, 10- and 20-mg caplets.
Thyroid 1/2 Grain, 30-mg tablets.
Tiagabine HCL, 4-mg tablets.
Ticlopidine Hydrochloride, 250-mg tablets.
Timolol Maleate, 5- and 10-mg tablets.
Tizanidine HCL, 2- and 4-mg tablets.
Tolazamide, 250-mg tablets.
Tolterodine Tartrate, 1- and 2-mg tablets and 2-mg caplets.
Tolterodine Tartrate ER, 4-mg tablets.
Topiramate, 25-mg tablets.
Topiramate Sprinkle, 15- and 25-mg caplets.
Torsemide, 5-, 10-, 20- and 100-mg tablets.
Tramadol HCL, 50-mg tablets.
Tramadol HCL ER, 100-mg tablets.
Trandolapril, 1-, 2- and 4-mg tablets.
Tranylcypromine Sulfate, 10-mg tablets.
Trazodone HCL, 50-, 100- and 150-mg tablets.
Tretinoin, 10-mg tablets.
Triamterene, 50-mg tablets.
Triamterene and Hydrochlorothiazide, 35.7/25-mg, 37.5/25-mg and 75/50-mg tablets.
Trifluoperazine HCL, 1-, 2- and 5-mg tablets.
Trihexyphenidyl HCL, 2- and 5-mg tablets.
Trimethobenzamide HCL, 300-mg tablets.
Trimethoprim, 100-mg tablets.
Trimipramine Maleate, 25-mg tablets.
Triprolidine HCL/Pseudoephedrine HCL, 2.5/60-mg tablets.
Trospium Chloride, 20-mg tablets.
Trospium Chloride ER, 60-mg tablets.
Univasc, 15-mg tablets.
Ursodiol, 250-mg tablets and 300-mg caplets.

CONSUMER PRODUCTS

Contact the Consumer Product Safety Commission (CPSC) for specific instructions or return the item to the place of purchase for a refund. For additional information from the CPSC, call its hotline at (800) 638-2772. The CPSC website is www.cpsc.gov. Visit www.recalls.gov for information about FDA recalls and recalls issued by other government agencies.

Name of Product; Problem; Recall Information

Arctic Cat All-Terrain Vehicle. The ATV's steering tie rod can bend, causing loss of control and posing a crash hazard. Arctic Cat Inc., at (800) 279-6851 or www.arctic-cat.com.

Ashland Glass Vase. The glass vases can break or fracture when a consumer picks them up, posing a laceration hazard. Michaels Stores Inc., at (800) 642-4235 or www.michaels.com.

Cub Scout Wind Tech Jackets. The jackets have retractable cords with toggles at the hood/neck area and at the waist that can pose a strangulation or entrapment hazard to children. In February 1996, CPSC issued guidelines, which were incorporated into an industry voluntary standard in 1997, to help prevent children from strangling or getting entangled on the neck and waist drawstrings in upper garments, such as jackets and sweatshirts. Boy Scouts of America, at (855) 873-2408 or www.scoutstuff.org.

Disney Fairies Plastic Racing Trikes. The plastic fairy figures protrude from the top of the handlebar, posing a laceration hazard if a child falls on them. Kiddieland Toys Ltd., at (800) 430-5307 or www.kiddieland.com.hk.

Drop-Side Cribs. The slats on the drop side can detach from the top and bottom rails, creating a space between the slats. An infant or toddler's body can become entrapped in the space, which can lead to strangulation and/or suffocation. A child can also fall out of the crib. Dutailier Group Inc., at (800) 363-9817.

Fantasy Glass Bowls. The glass bowl can break when subjected to sudden temperature changes or impact, posing a laceration hazard to consumers. Libbey Glass Inc., at (800) 982-7063 or www.libbey.com.

Joss Rock Climbing Cam. The recalled cams can fail unexpectedly after being set, posing a fall hazard. Cassin Sri, at (800) 713-4534 or customerservice@sierratradingpost.com.

KEDS "Know It All" Girls' Shoe. Ornamental stars on the heel of the shoe may loosen, posing a laceration hazard. Collective Brands Inc., at (800) 365-4933 or www.collectivebrands.com.

Kidgets Animal Sock Top Slippers. The eyes can detach from the slippers, posing a choking hazard to young children. BCNY International Inc., at (800) 547-0359 or www.familydollar.com.

Liebherr Freestanding 30-Inch Wide, Bottom Freezer Refrigerators. The refrigerator's door can detach, posing an injury hazard to consumers. Liebherr-Hausgeraete Lienz GmbH, at (877) 337-2653 or www.liebherr.us.

Omni-Heat Lithium-Polymer Rechargeable Batteries. The batteries have a cell defect that can cause overheating, posing a fire hazard. Columbia Sportswear Co., at (800) 622-6953 or www.Columbia.com/Recall.

PAX AURLAND Wardrobe Mirror Doors. The mirror glass can detach unexpectedly from the wardrobe door, fall and shatter, posing a laceration hazard to consumers. IKEA North America Service, at (888) 966-4532 or www.ikea-usa.com.

Swimwear Set With Inflatable Inner Tube. The inner tube accessory can be pulled over a small child's head, posing a strangulation hazard. Build-A-Bear Workshop, at www.buildabear.com.

Toulouse-LapTrec Magnetic Sketchboards. The magnetic tip of the drawing pen can dislodge from the pen, posing a choking hazard to children. Rainbow Force Plastic Products, at (866) 665-5524 or www.battatco.com.

UA Defender Chin Straps. The metal snap that connects the chin strap to the helmet has sharp edges, posing a laceration hazard when the user's metal snap comes into contact with another player. JR286 Inc., at (888) 823-0343 or www.underarmour.com.

Winchester Hunting Knife Sets. The latching mechanism for the knife's interchangeable blades can unexpectedly fail and release the blade. This poses a laceration hazard to consumers. Gerber Legendary Blades, at (877) 314-9130 or www.gerbergear.com.

Wolfgang Puck Electric Reversible Tri-Grill/Griddles. This recall includes Wolfgang Puck-brand combination electric grills/griddles with dual thermostatic controls and model number BRTGG010. The grills measure about 14.5 inches in width, 11 inches in depth and 6.5 inches in height. The model number is located on an ETL/Intertek foil sticker label affixed to the bottom of the unit. The stainless steel grills/griddles have "Wolfgang Puck Bistro Collection" stamped on the front of the unit next to the control dials. They feature a stainless steel handle used to compress the top and bottom grill plates. YouO Electric Appliances Co. Ltd., at (855) 666-0478 or www.brtgg010-recall.com.

OUTRAGE, from page 12

Truth and Transparency said in that group's statement on the Pfizer-PBM deal. "While the Lipitor co-pay will drop on November 30 [to the same as the generic co-pay], the full price to plan sponsors will stay the same. That means plan sponsors will be forced to pay more for brand Lipitor, even though a low cost generic is available."

Note that plan sponsors include employers and Medicare Part D, which means taxpayers absorb the higher cost as well.

"This is just an egregious case. Clearly, there's been some negotiation between Pfizer and the large PBM's saying we're going to make this cost-beneficial to them, but the plan sponsors are going to eat it," Geoffrey F. Joyce, an associate professor of clinical pharmacy and pharmaceutical economics and policy at the University of Southern California, told *The New York Times*.

This newest version of pay-for-delay (bribing PBMs) comes on the heels of the still-popular older version, wherein brand-name companies legally "bribe" generic companies to hold off introducing their drugs for a certain period of time after a drug's patent expires. Brand-name companies pay generic companies tens of millions of dollars for this profitable delay. Legislation making this behavior illegal in most instances is stalled because of the overwhelming presence of drug-industry lobbyists and campaign contributions from the industry here in the nation's capital of influence-peddling.

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This is not the only desperate, aggressive tactic Pfizer is using to preserve as many Lipitor sales as possible. As most people reading U.S. newspapers have learned, for nearly a year, the company has been offering "co-pay" programs that reduce out-of-pocket costs for insured patients to $4 a month.

These so-far legal money-making schemes only add to the illegal — but unfortunately still money-making — activities of the pharmaceutical industry that have warranted almost $20 billion in civil and criminal penalties in the past 20 years. Coincidentally, the largest criminal penalty ever paid by any U.S. company was Pfizer's $1.2 billion in September 2009 (we wrote about this in our 2010 "Rapidly Increasing Criminal and Civil Monetary Penalties Against the Pharmaceutical Industry: 1991 to 2010" report). ✦

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Outrage of the Month!
More Despicable Drug-Industry Behavior

If you are a drug company that sells an important and effective drug — the best-selling drug ever, having brought in $106 billion in sales over the last decade, according to *The New York Times* — what do you do when the patent expires on Dec. 1 of this year and a much lower-priced, generic version becomes available?

If the company is Pfizer and the drug is Lipitor (generic name: atorvastatin), you make a deal with the biggest pharmacy benefit management (PBM) company in the world, Medco. PBMs act as middlemen between drug companies selling their drugs and insurers and employers sponsoring insurance plans that purchase the drugs. Because of the Pfizer-PBM deal, starting Dec. 1, when generic atorvastatin becomes available in drug stores, patients whose drug benefits are managed by Medco will not be able to purchase the generic version but will be forced to get Lipitor, although their doctors have written a prescription for generic atorvastatin.

Even if this "deal" only lasts for six months, after which many more generic companies will be allowed to flood the market with their versions of atorvastatin, Pfizer will reap an additional $700 million in 2012 alone, compared to what they would have made if such a deal had not been

sealed, according to Wall Street drug-company analyst Dr. Tim Anderson. This is because it will significantly slow the pace of the ultimate switch to the generic version.

Who benefits from this? Clearly, Pfizer and probably PBMs such as Medco, although Medco has denied it will profit from the deal. Who loses? Although patients will, at least temporarily, be able to pay the same deductible for Lipitor as they do for the generic version, some employers and insurance companies will dish out more money for the needlessly expensive Lipitor instead of being able to pay for less expensive generic atorvastatin.

"The move is a blatant attempt by PBMs to retain rebate dollars from Lipitor's manufacturer," David Marley of Pharmacists United for

see OUTRAGE, page II