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Treatment Issues in Multiple Sclerosis in Latin America

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Treatment issues of multiple sclerosis (MS) in Latin America (LA) have recently been addressed [1, 2]. Some particular features of the health systems, patients and medical providers are scarcely described. Moreover, LA patients are rarely included in clinical trials; therefore, data collected from key opinion leaders (KOL) from LA, although unofficial, remain as a needed source of information.

In a stand-alone gathering, organized by a pharmaceutical company, in Brazil 2014, according to 'Compliance Program Guidance for Pharmaceutical Manufacturers' [3], we surveyed the opinion of KOL in MS from 6 LA countries. Neurologists were selected and invited to the gathering based on their academic, research and clinical experience with MS patients and involvement as participants and speakers on regional events.

A voluntary anonymous electronic survey was proposed in an interactive lecture (table 1). Important definitions were given previously without further discussion on the topic to avoid biased answers.

Early initiation of therapy and adherence in MS is of utmost importance. LA KOL report a fair amount of time during their patients' DMD initiation visit, which could be a good indicator of important therapy aspects being discussed with the patient and their families. KOL were adherent to LA guidelines about the scheduled frequency of patient's visits per year to the outpatient clinic [4]. On the other hand, most neurologists relied on self-report when evaluating adherence. Continuous support and follow-up by a dedicated trained staff have been related to better outcomes in MS. However, MS neurologists in our region are scarce and the situation regarding MS nurses might be even worse [5].

Only one third of KOL declared that over 80% of their patients kept the original treatment at the end of the first year. The main reason for treatment discontinuation was tolerability (injection stress, skin reactions, and injection pain), in contrast to global MS patients registered in the NARCOMS database, who discontinue treatment due to perceived lack of efficacy (no perceived benefit from the treatment, or worsening MS symptoms or disability) [6, 7]. These results could also be explained by impaired availability of DMD, because of administrative issues and interchangeability among drugs.

Regarding LA Health Systems, we found a perceived improvement in treatment coverage. In 2011, experts estimated that below 35% of the LA population had access to DMDs [2]. In contrast, KOL now estimate greater proportions of their patients accessing these treatments. Nonetheless, KOL perceive that bureaucracy and corruption interfere with the availability of treatment.

Our survey showed LA KOL try to offer the best treatment to their patients, sometimes balancing costs, but they agree in never using immune-suppressors instead of DMDs in order to save money. Similarly, although biosimilars may represent a cheaper treatment option, LA KOL showed a remarkable uncertainty about their safety and efficacy that can explain the divided attitudes toward their use, which brings to spotlight the urgent need of clinical trials.

Fair access to DMD, issues related to adherence, health systems, the uncertainty about biosimilars, are some of the obstacles that are yet to be overcome in the treatment of patients with MS in LA.

Disclaimers

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TEVA Pharmaceutical Industries sponsored the stand-alone gathering in Brazil 2014.

Disclosure of Interests

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Table 1. Questionnaire and answers

Questions	A % (n)	B % (n)	C % (n)	D % (n)	E % (n)
Q1: On average, how many patients with MS do you see per month? (n = 52)	<1/month 12 (6)	1–5/month 38 (20)	6–15/month 35 (18)	6–30/month 12 (6)	30/month 4 (2)
Q2: From the total of your patients starting a DMD therapy, what percentage of them do you consider keep taking the original treatment at the end of the first year? (n = 53)	less than 20% 2 (1)	21–40% 11 (6)	41–60% 17 (9)	61–80% 38 (20)	more than 80% 32 (17)
Q3: On average, how much time do you spend in the first visit for DMD therapy initiation in your outpatient service? n = 54	<15 min 0 (0)	15–30 min 11 (6)	31–45 min 44 (24)	45–60 min 28 (15)	>60 min 17 (9)
Q4: On average, how often do your MS patients book a visit in the outpatient clinic? (n = 54)	once in a year 2 (1)	twice in a year 20 (11)	three to four times in a year 54 (29)	every two months 13 (7)	monthly 11 (6)
Q5: According to the definitions previously presented, which would be the leading reason for stopping injectable DMD in your patients? (n = 53)	lack of efficacy 19 (10)	safety concerns 4 (2)	tolerability issues 58 (31)	burden 19 (10)	
Q6: How do you usually evaluate medication compliance in your MS patient? (n = 54)	rely in self report 61 (33)	use diaries of medication 17 (9)	surveillance reports from industry or pharmacy 6 (3)	electronic monitoring devices 2 (1)	dedicated staff, from your facility, in charge to offer support 15 (8)
Q7: What percentage of your DMD-requiring patients will actually receive it from your national health system (insurance companies, social security or government)? (n = 54)	0–25% 3 (1)	26–50% 11 (6)	51–75% 26 (14)	76–100% 61 (33)	
Q8: How often does the bureaucracy of your health system delay the treatment onset or impair its continuity? (n = 54)	never 4 (2)	rarely 20 (11)	sometimes 33 (18)	frequently 28 (15)	almost always 15 (8)
Q9: Do you consider that corruption is an issue that affects the availability of DMDs in your health system? (n = 53)	not at all 9 (5)	rarely 9 (5)	sometimes 26 (14)	frequently 34 (18)	almost always 21 (11)
Q10: Which of the next statements would fit better with your way of thinking about drug treatment for MS patients? (n = 54)	I try to offer the best to my patient, costs are not of my concern 54 (29)	I try to balance the cost of medications with the needs of my patient 37 (20)	I always consider cost of medication in my clinical decision 7 (4)	Sometimes, I think the money spent in MS could have a more important use 2 (1)	I would prefer to use immunosuppressors, such as azathioprine, to save money 0 (0)
Q11: Are DMDs Biosimilars currently in use in your health system? (n = 54)	yes 56 (30)	no 44 (24)			
Q12: Which of the next statements would fit better with your opinion about biosimilars in MS? (n = 54)	I have used Biosimilars and I have not found differences with innovatives (original) DMD 4 (2)	I have used Biosimilars and I have found worst results (less efficacy or more side effects) 11 (6)	I have used Biosimilars but I can't asses differences because short term experience or interchangeability among drugs 24 (13)	I have not used Biosimilars but would try them 28 (15)	I have not used Biosimilars and would never try them 33 (18)
Participants were from Brazil (21), Argentina (28), Mexico (13), Colombia (8), Peru (4), Chile (3).					

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