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## Superior efficacy of new medicines?

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### Superior efficacy of new medicines?

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Review

**Superior efficacy of new medicines?***Johan C.F. van Luijn*<sup>1,2</sup>, *Frank W.J. Gribnau*<sup>3</sup>, *Hubert G.M. Leufkens*<sup>1</sup>

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Words article: 1530

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Table: 1

Figure: 1

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**Abstract****Purpose**

To give an overview of and to discuss new authorized medicines with an improved efficacy.

**Methods**

[The analysis focused on new medicines with an improved efficacy based on randomised active control trials.](#)

Information on comparative efficacy was obtained from the EMEA European Public Assessment Reports.

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**Results**

Between 1999 and 2005 we identified 122 new medicines with a new active substance; for 13 (10%) medicines superiority was demonstrated [in case of a statistically significant difference in primary clinical endpoints.](#)

**Conclusions**

A proven advantage in efficacy at an early stage of drug development is the exception rather than the rule. The absence of evidence for differences between medicines does not mean the absence of differences. Optimal pharmacotherapy would benefit from more comparative research in the development of new medicines. Results of comparative trials need a critical evaluation of their specific value to clinical practice. Prescription data may be helpful.

**Keywords:**

Randomized active control trials, superiority trials, comparative information, market authorization, added therapeutic value

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## Introduction

The goal of developing new medicines should be an improvement in treatment: the new medicine should benefit patients when compared to previously existing options [1-4].

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This added therapeutic value might lie in different properties such as efficacy, safety, applicability, convenience of administration, etc., the first two of which are considered as the most important: a new, more efficacious and/or safer medicine.

Demonstrating any improvement is not an explicit condition for being granted marketing authorization. Data on quality, efficacy and safety are therefore needed in order to demonstrate a favourable benefit/risk ratio when treating a patient for the claimed therapeutic indication. For that purpose, placebo controlled trials provide robust evidence [5,6]. However, regulatory authorities also want to be sure that, for new medicines for which good alternatives are available, the possibility has been excluded that patients are treated with a product that is less efficacious or less safe [7]. Files submitted to the regulatory authorities can include studies that demonstrate efficacy by confirming the absence of a difference (equivalence trial), or by showing that the new medicine is no worse than an existing medicine (noninferiority trial). Besides this, efficacy can also be demonstrated by showing an improved efficacy compared with a medicine already used in practice for the same claimed therapeutic indication (superiority trial). It goes without saying that the results of these trials are particularly interesting as they inform us how new medicines, accurately estimated for their efficacy, contribute to an improvement in treatment for patients. Statistics on the extent of superior medicines as a result of the marketing authorization process are scarce.

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The aim of this study is to give an overview of and to discuss new authorized medicines with an improved efficacy.

## Methods

We did a further analysis of the data from a previous study about the availability of comparative information on new medicines at the moment of European market authorization [8]. We therefore analyzed the European Public Assessment Reports (EPARs) of the European Medicines Agency (EMA) between 1999 and 2005 on new medicines with a new active substance [9]. [The analysis focused on new medicines with an improved efficacy based on randomised active control trials \(RaCTs\)](#). Data about the RaCTs, extracted from the EPARs included therapeutic indication, objective, comparator, design, clinical endpoints, results and the conclusion of the Committee for Medicinal Products for Human Use (CHMP) on comparative efficacy.

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## Results

Between 1999 and 2005 we identified 122 new medicines with a new active substance, of which 58 (48%) had been studied in comparison with existing medicines. Of the main/pivotal active control trials (N=153), the objective of 15 (10%) was to show superiority: for 4 trials this objective failed. [For bimatoprost, fondaparinux,](#)

peginterferon alfa-2a, peginterferon alfa-2b and tipranavir the objective demonstrating superiority was realized. A difference in efficacy was also demonstrated in 13 trials with the primary objective to show noninferiority or equivalence. The medicines were considered as superior in case of a statistically significant difference in primary clinical endpoints. In total superiority was demonstrated in 24 trials for 13 (10%) new medicines (see table 1).

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Discussion

Ideally, claims regarding an added value of a new medicine should be based on the results of comparative trials [3,10]. In a previous study we found that nearly one out of two new medicines had been studied in a randomized active control trial [8]. Further analysis of the data on comparative efficacy shows that an improvement was demonstrated for only one out of ten new medicines. Despite this small number, the conclusion cannot simply be drawn that the advance in pharmacotherapy is restricted to these new medicines. Nevertheless, this means there is sufficient reason to adopt a critical attitude towards claims of pharmaceutical companies regarding an added value of their new products.

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A number of observations can be made regarding this result. Firstly, our analysis excluded new medicines for which no alternative was available and for which, inevitably, a comparative trial was lacking. However, developed as the first medicinal therapy for life-threatening or serious diseases, such medicines – for example, orphan drugs - can rightfully be considered an improvement in the treatment of patients. Secondly, we only focused on differences in efficacy and not on properties such as safety, applicability or convenience of administration. The reason is that main/pivotal trials are used in particular for demonstrating efficacy. Nevertheless, new medicines whose efficacy is equivalent or noninferior may have advantages in safety. For example, tenecteplase used in the treatment of suspected myocardial infarction; based on a study in 17005 patients, although it shows equivalence compared to alteplase, the safety profile seems to be in favour of tenecteplase [11].

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Another reason for the small number of innovations is that, for granting market authorization, demonstrating advantages is not an objective in itself. So there is no need or requirement to conduct a trial with such an objective. Moreover, pharmaceutical companies would be taking a substantial risk, as failure to demonstrate superiority over a less expensive existing drug could be a financial disaster. The fact that, on the other hand, a positive result could be expected to lead to substitution of the comparator, appears to carry less weight.

Furthermore, we should comment that whether the 13 medicines in our analysis really are an improvement in therapy depends on a sound review of all relevant properties, the clinical relevance of the differences and the appropriateness of the comparator. It is important always to weigh up the advantages and disadvantages meticulously. This also applies to the medicines in our study, as far as possible with the data in the EPAR. For most studies the EPAR did not provide the basic details of trial design and results in a uniform fashion.

According the EPAR, the efficacy of bimatoprost and travoprost is superior to timolol in the treatment of glaucoma, but their safety profile is inferior due to a higher frequency of ocular side effects. The trial on

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tipranavir demonstrates a superior antiviral activity, but also a higher frequency of hepatic events and lipodystrophy. Moreover, comparative efficacy is always linked to a specific comparator, therapeutic indication and type of patients. Emtricitabine was more efficacious compared with stavudine in naive HIV-infected patients. However, its efficacy was inferior in comparison with lamivudine in the same type of patients; its efficacy was similar in a study that compared it with lamivudine in experienced patients.

Regarding the appropriateness of the comparator, we can conclude, referring to a previous study, that the choice of the compator in the trials that demonstrated superiority was in line with recommendations on standard treatment [12].

Another issue in a critical evaluation of demonstrated superiority is the choice of the primary clinical endpoint. A composite endpoint was used for fondaparinux; analysis of all the endpoint events shows that the incidence of symptomatic venous thromboembolic events, including pulmonary embolism, was not significantly different between treatment groups [13,14].

Furthermore, we have to realise that drawing a conclusion of superiority based on a statistically significant difference says nothing about its practical significance. The absolute differences in change of glycated haemoglobin (HbA1c), demonstrated for insulin aspart and insulin glulisine compared to regular insulin, were, at best, of limited clinical relevance. Moreover, there was no relevant difference regarding the incidence of hypoglycaemic events. In this context it is interesting to follow developments in the prescription of fast-acting insulin in the treatment of diabetes, as the results of clinical studies may not always be reflected in practice [15,16]. For prescription data, we used the GIP database of the Health Care Insurance Board in the Netherlands.

This database contains data on the prescription of extramural medicines, obtained from health insurance organisations and based on a sample of more than 12 million people. Graph 1 shows developments in the usage before and after the introduction of insulin aspart. The degree to which insulin aspart is used cannot be completely explained on the results of the premarketing trials. The more rapid onset and shorter duration of action of the insulin analogue is thought to facilitate a more flexible life style in comparison with the use of soluble human insulins [17]. However, this should also apply to insulin lispro, which can be regarded as being comparable to insulin aspart [18].

Finally, significant advantages as well as disadvantages of new medicines may only become evident during the course of time, on the basis of further study and experience. This means that assessing the added value of a new medicine is not a one-off incident but a continual process, supported by monitoring usage by means of prescription data.

This study shows and discusses how proven superiority, in the sense of well-demonstrated advantages in efficacy at an early stage of drug development, is the exception rather than the rule. The absence of evidence for differences between medicines does not mean the absence of differences. Insight into differences and similarities between medicines, however small they may be, is important in order to make the right choice for the right patient in clinical practice. Therefore, optimal pharmacotherapy would benefit from more comparative research in the development of new medicines. This study also shows that the results of comparative trials need a critical evaluation of their specific value to clinical practice. Prescription data may be helpful.

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Table 1 - New medicines (1999-2005) with an improved efficacy

New medicine	Indication	Comparator
Bimatoprost	Glaucoma	Timolol
Capecitabine	Colorectal cancer	5-FU/Folonic acid
Emtricitabine	HIV-infections (combination)	Stavudine
Fondaparinux	Prevention of venous thromboembolic events	Enoxaparine
Insulin aspart	Diabetes mellitus type 1	Insulin regular human
Insulin glulisine	Diabetes mellitus type 2	Insulin regular human
Lopinavir	HIV-infections (combination)	Nelfinavir
Peginterferon alfa 2a	Chronic hepatitis C	Interferon alfa 2b
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Tipranavir	HIV-infections (combination)	Protease inhibitors
Travoprost	Glaucoma	Timolol
Voriconazole	Invasive aspergillosis	Amfotericin B (conv)
Zoledronic acid	Hypercalcaemia (tumour-induced)	Pamidronate

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The aim of this study is to give an overview of and to discuss new authorized medicines with an improved efficacy.

## Methods

We did a further analysis of the data from a previous study about the availability of comparative information on new medicines at the moment of European market authorization [8]. We therefore analyzed the European Public Assessment Reports (EPARs) of the European Medicines Agency (EMA) between 1999 and 2005 on new medicines with a new active substance [9]. The analysis focused on new medicines with an improved efficacy based on randomised active control trials (RaCTs). Data about the RaCTs extracted from the EPARs included therapeutic indication, objective, comparator, design, clinical endpoints, results and the conclusion of the Committee for Medicinal Products for Human Use (CHMP) on comparative efficacy.

## Results

Between 1999 and 2005 we identified 122 new medicines with a new active substance, of which 58 (48%) had been studied in comparison with existing medicines. Of the main/pivotal active control trials (N=153), the objective of 15 (10%) was to show superiority: for 4 trials this objective failed. For bimatoprost, fondaparinux,

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3 peginterferon alfa-2a, peginterferon alfa-2b and tipranavir the objective demonstrating superiority was realized.  
4 A difference in efficacy was also demonstrated in 13 trials with the primary objective to show noninferiority or  
5 equivalence. The medicines were considered as superior in case of a statistically significant difference in primary  
6 clinical endpoints. In total superiority was demonstrated in 24 trials for 13 (10%) new medicines (see table 1).  
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## 10 11 **Discussion**

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13 Ideally, claims regarding an added value of a new medicine should be based on the results of comparative trials  
14 [3,10]. In a previous study we found that nearly one out of two new medicines had been studied in a randomized  
15 active control trial [8]. Further analysis of the data on comparative efficacy shows that an improvement was  
16 demonstrated for only one out of ten new medicines. Despite this small number, the conclusion cannot simply be  
17 drawn that the advance in pharmacotherapy is restricted to these new medicines. Nevertheless, this means there  
18 is sufficient reason to adopt a critical attitude towards claims of pharmaceutical companies regarding an added  
19 value of their new products.  
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26 A number of observations can be made regarding this result. Firstly, our analysis excluded new medicines for  
27 which no alternative was available and for which, inevitably, a comparative trial was lacking. However,  
28 developed as the first medicinal therapy for life-threatening or serious diseases, such medicines – for example,  
29 orphan drugs - can rightfully be considered an improvement in the treatment of patients. Secondly, we only  
30 focused on differences in efficacy and not on properties such as safety, applicability or convenience of  
31 administration. The reason is that main/pivotal trials are used in particular for demonstrating efficacy.  
32 Nevertheless, new medicines whose efficacy is equivalent or noninferior may have advantages in safety. For  
33 example, tenecteplase used in the treatment of suspected myocardial infarction; based on a study in 17005  
34 patients, although it shows equivalence compared to alteplase, the safety profile seems to be in favour of  
35 tenecteplase [11].  
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42 Another reason for the small number of innovations is that, for granting market authorization, demonstrating  
43 advantages is not an objective in itself. So there is no need or requirement to conduct a trial with such an  
44 objective. Moreover, pharmaceutical companies would be taking a substantial risk, as failure to demonstrate  
45 superiority over a less expensive existing drug could be a financial disaster. The fact that, on the other hand, a  
46 positive result could be expected to lead to substitution of the comparator, appears to carry less weight.  
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51 Furthermore, we should comment that whether the 13 medicines in our analysis really are an improvement in  
52 therapy depends on a sound review of all relevant properties, the clinical relevance of the differences and the  
53 appropriateness of the comparator. It is important always to weigh up the advantages and disadvantages  
54 meticulously. This also applies to the medicines in our study, as far as possible with the data in the EPAR. For  
55 most studies the EPAR did not provide the basic details of trial design and results in a uniform fashion.  
56 According the EPAR, the efficacy of bimatoprost and travoprost is superior to timolol in the treatment of  
57 glaucoma, but their safety profile is inferior due to a higher frequency of ocular side effects. The trial on  
58 tipranavir demonstrates a superior antiviral activity, but also a higher frequency of hepatic events and  
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lipodystrophy. Moreover, comparative efficacy is always linked to a specific comparator, therapeutic indication and type of patients. Emtricitabine was more efficacious compared with stavudine in naive HIV-infected patients. However, its efficacy was inferior in comparison with lamivudine in the same type of patients; its efficacy was similar in a study that compared it with lamivudine in experienced patients.

Regarding the appropriateness of the comparator, we can conclude, referring to a previous study, that the choice of the comparator in the trials that demonstrated superiority was in line with recommendations on standard treatment [12].

Another issue in a critical evaluation of demonstrated superiority is the choice of the primary clinical endpoint. A composite endpoint was used for fondaparinux; analysis of all the endpoint events shows that the incidence of symptomatic venous thromboembolic events, including pulmonary embolism, was not significantly different between treatment groups [13,14].

Furthermore, we have to realise that drawing a conclusion of superiority based on a statistically significant difference says nothing about its practical significance. The absolute differences in change of glycated haemoglobin (HbA1c), demonstrated for insulin aspart and insulin glulisine compared to regular insulin, were, at best, of limited clinical relevance. Moreover, there was no relevant difference regarding the incidence of hypoglycaemic events. In this context it is interesting to follow developments in the prescription of fast-acting insulin in the treatment of diabetes, as the results of clinical studies may not always be reflected in practice [15,16]. For prescription data, we used the GIP database of the Health Care Insurance Board in the Netherlands. This database contains data on the prescription of extramural medicines, obtained from health insurance organisations and based on a sample of more than 12 million people. Graph 1 shows developments in the usage before and after the introduction of insulin aspart. The degree to which insulin aspart is used cannot be completely explained on the results of the premarketing trials. The more rapid onset and shorter duration of action of the insulin analogue is thought to facilitate a more flexible life style in comparison with the use of soluble human insulins [17]. However, this should also apply to insulin lispro, which can be regarded as being comparable to insulin aspart [18].

Finally, significant advantages as well as disadvantages of new medicines may only become evident during the course of time, on the basis of further study and experience. This means that assessing the added value of a new medicine is not a one-off incident but a continual process, supported by monitoring usage by means of prescription data.

This study shows and discusses how proven superiority, in the sense of well-demonstrated advantages in efficacy at an early stage of drug development, is the exception rather than the rule. The absence of evidence for differences between medicines does not mean the absence of differences. Insight into differences and similarities between medicines, however small they may be, is important in order to make the right choice for the right patient in clinical practice. Therefore, optimal pharmacotherapy would benefit from more comparative research in the development of new medicines. This study also shows that the results of comparative trials need a critical evaluation of their specific value to clinical practice. Prescription data may be helpful.



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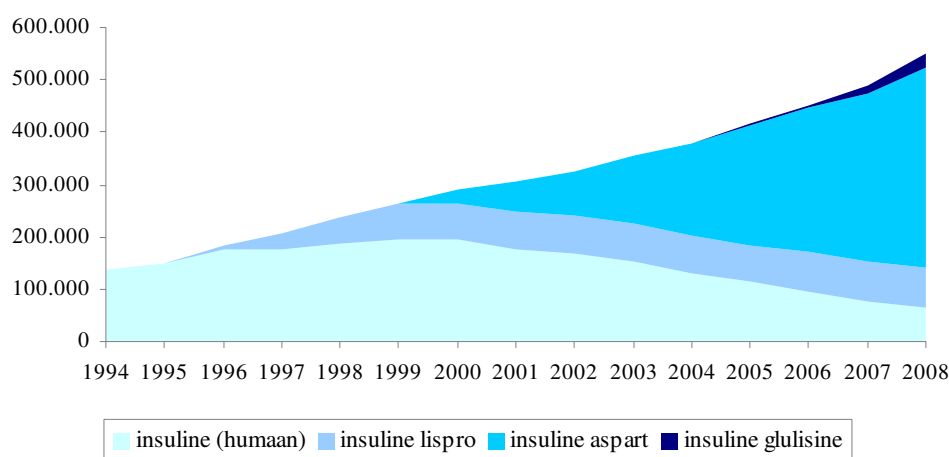
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**Table 1 - New medicines (1999-2005) with an improved efficacy**

New medicine	Indication	Comparator
Bimatoprost	Glaucoma	Timolol
Capecitabine	Colorectal cancer	5-FU/Folonic acid
Emtricitabine	HIV-infections (combination)	Stavudine
Fondaparinux	Prevention of venous thromboembolic events	Enoxaparine
Insulin aspart	Diabetes mellitus type 1	Insulin regular human
Insulin glulisine	Diabetes mellitus type 2	Insulin regular human
Lopinavir	HIV-infections (combination)	Nelfinavir
Peginterferon alfa 2a	Chronic hepatitis C	Interferon alfa 2b
		Interferon alfa 2a
Peginterferon alfa 2b	Chronic hepatitis C	Interferon alfa 2b
Tipranavir	HIV-infections (combination)	Protease inhibitors
Travoprost	Glaucoma	Timolol
Voriconazole	Invasive aspergillosis	Amfotericin B (conv)
Zoledronic acid	Hypercalcaemia (tumour-induced)	Pamidronate

**Graph 1. Development number prescriptions of fast-acting insulins**

After the introduction of insulin aspart in 1999 there was a decrease in the number of prescriptions of soluble human insulin, however the use was already decreasing since the introduction of insulin lispro in 1996. Since 2004 insulin aspart is the most prescribed fast-acting insulin. The introduction of insulin glulisine in 2005 had little impact on the number of prescriptions of the other insulins.