New Law Puts Pseudoephedrine Behind Counter

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

Over-the-counter drugs containing pseudoephedrine will go behind the counter beginning in late September under a new law passed by Congress and signed by President Bush.

The Combat Methamphetamine Epidemic Act of 2005—passed as part of the reauthorization of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT) Improvement and Reauthorization Act of 2005—requires consumers who wish to purchase pseudoephedrine-containing over-the-counter medicines to show photo identification and sign a log book. It also limits the amount of pseudoephedrine-containing products that can be purchased to 3.6 g per day and 9 g within a 30-day period.

Rep. Roy Blunt (R-Mo.), one of the supporters of the legislation, said the new law will help combat methamphetamine abuse. "Easy access to common cold medicine is a meth cook's dream come true," Rep. Blunt said in a statement. "The most effective way to fight the meth epidemic is to make it harder for criminals to get the key ingredient in the production of this deadly drug."

Dr. Punyamurtula S. Kishore, an addiction medicine specialist in Chestnut Hill, Mass., agreed, although he noted that it wouldn't solve the problem completely. "[Pseudoephedrine] is the chief ingredient in the whole cooking process," said Dr. Kishore. "Any controls are good controls."

Dr. Maurice Ramirez, an emergency physician in Orlando, Fla., and a drug-testing professional for the Nuclear Regulatory Commission regulated industries, said that one reason cold medicines are being put behind the counter is to reduce the number of addicts who buy raw materials for their suppliers. "When you're taking meth, you look like you have a cold anyway, so the addicts buy a cartload of cold medicines and credit it against their account at the pusher," he said. "It's foolish for [manufacturers] to go to the store and get their own pseudoephedrine, because they know that's where people are watching."

Dr. Ramirez noted that the law also applies to sales of cold medicines on the Internet, which is one way many suppliers get them. "Many can just buy it over the Internet in large bulk amounts if they have a solid address and can generate the appropriate fake paperwork. It's harder to get the ammonia you need than it is to get cold medicine components. That part [of the law] is to counter crime and I think that's appropriate," although it doesn't solve the problem of demand for meth.

'It's easier to make meth with ephedrine and pseudoephedrine; if you take [them] off the shelf, it makes [addicts'] lives harder but it doesn't mean they can't make it.'

Not everyone was as supportive. "This will not solve the problem," said Dr. Akikur R. Mohammad of the psychiatry and behavioral sciences department at the University of Southern California, in Los Angeles. "It's easier to make meth with ephedrine and pseudoephedrine; if you take those medicines off the shelf, it makes [addicts'] lives harder but it doesn't mean they can't make it."

Instead, said Dr. Mohammad, who is also medical director of Malibu Horizon, a residential substance abuse treatment facility, "We have to educate people that addiction is a disease, that it can cause problems with health. And when people are addicted, we have to aggressively treat them."

Bill Piper, director of national affairs for the Drug Policy Alliance, a Washington-based group that emphasizes treatment over criminal prosecution for drug addicts, agreed. "I don't think it's going to have any impact," he said. "It's not going to reduce the availability of methamphetamine, nor is it going to reduce the number of people addicted to meth. At the most, all it's going to do is reduce homemade meth."

Laws similar to the Combat Methamphetamine Epidemic Act have previously been enacted in several states. In response to the reduction in available homemade methamphetamine, "Mexican-based drug cartels moved in," Mr. Piper added. "As long as demand is there,

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Survey Dispels Worries of Genetic Bias by Insurers

BY BRUCE JANCIN

Denver Bureau

SAN ANTONIO — The specter of discrimination based on genetic test results has turned out to be greatly overblown, Dr. Kenneth Offit said at a breast cancer symposium sponsored by the Cancer Therapy and Research Center.

"It's a topic we've heard a lot about. Maybe too much," added Dr. Offit, chief of the clinical genetics service at the Memorial Sloan-Kettering Cancer Center, New York. "Forty percent of our patients come in saying that this is their major concern, not medical issues. They're worried they'll lose their insurance and that employers will discriminate against them.

'We've asked them, and not one of them has had an episode ... in the workplace or their insurance.'

DR. OFFIT

This is a profound concern," he noted.

Yet this concern has not been borne out in the more than 4,000 patients at Sloan-Kettering who have undergone genetic testing, nor has it been confirmed in the 600 known cancer mutation carriers who are being followed there on a regular basis.

"We've asked them, and not one of them has had an episode of genetic discrimination in the workplace or their insurance," the oncologist continued.

Similarly, a careful seven-state survey conducted a few years ago found no cases of genetic discrimination (Am. J. Hum. Genet. 2000;66:293-307). "Yet the press and the media still harp on the issue of genetic discrimination," he said.

"Insurance companies in North America are paying for genetic testing, they're paying for counseling, and they're paying for preventive surgery. And in one of the least-told stories around, companies like Blue Cross/Blue Shield and Aetna in New York don't require that genetic test results even go back to them," Dr. Offit said.

Two federal statutes—the Americans with Disabilities Act and HIPAA—protect patients from genetic discrimination. There is also a federal precedent in the form of a Burlington Northern and Santa Fe Railway Company settlement with the Equal Employment Opportunity Commission that helps protect the medical confidentiality of genetic test results. Moreover, in 2003 the U.S. Senate unanimously passed a bill banning discrimination in employment or health insurance based on genetic testing. The bill hasn't passed in the House of Representatives simply because genetic discrimination is no longer seen as a priority concern there, he said.

Yet genetic discrimination continues to be a high-visibility worry for the public—and this can have destructive consequences. For instance, in a 384-patient study, 14% of women at risk for hereditary breast cancer declined BRCA mutation testing because of concern about insurance discrimination, and based on testing of other women in the study, one-half of those who declined testing would have been expected to be BRCA positive (Cancer Epidemiol. Biomarkers Prev. 2002;11:79-87). ■

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there is going to be a supply."

If addicts don't buy the meth directly from a cartel, there are ways to cook it without using cold medicines, although it is more complicated without the ephedrine or pseudoephedrine, Dr. Mohammad said. "Now they will have to turn to people who are more educated and have more knowledge in chemistry."

The Combat Methamphetamine Epidemic Act also included other provisions related to helping meth addicts and their families. Mr. Piper pointed to one provision sponsored by Rep. Sheila Jackson Lee (D-Tex.) that creates grant programs to establish treatment centers for parenting and pregnant women.

"Generally speaking, most drug users tend to be men, but when it comes to meth, about 50% are women," he said. "There is a huge lack of resources for drug treatment for women, especially women with children. If you are [being treated] in-house, you can't bring your child with you, and if you are an outpatient and you don't have child care, it's much more difficult." ■

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