

LETTER FROM THE EDITOR



Given growing concerns about the cost of healthcare, physicians are increasingly having to consider 2 questions: Is this treatment effective? If so, is it cost-effective? While the second question may feel like an intrusion into the “traditional” practice of medicine, consideration of cost-effectiveness is essential, as we cannot properly care for all our patients unless we find ways to distribute limited resources in an efficient manner. Indeed, the ongoing healthcare debate is largely about developing programs and policies that can address this challenge.

While much of this debate is occurring in the political arena, clinicians can also observe how concerns about cost-effectiveness affect daily practice. In some cases, undue focus on cost-effectiveness can be detrimental, as when patients cannot afford a needed medication because it is not covered by their health insurance. However, concerns about cost-effectiveness do not always limit quality of care; in fact, considering the cost-effectiveness of a particular healthcare strategy can sometimes prompt better care. For example, preventative medicine has been encouraged by some managed care plans in large part because it is cost-effective, but individual patients certainly benefit when medical problems are prevented or treated earlier.

The cost-effectiveness of liver transplantation has recently received considerable attention. While liver transplantation is an effective treatment for patients with end-stage liver disease, the procedure and subsequent postoperative care are often quite costly. Indeed, last month’s article on factors that predict readmission following liver transplantation cited concerns about costs as one of the motivations for this study.

In the current issue of *Gastroenterology & Hepatology*, the cost-effectiveness of liver transplantation is addressed more directly. In an article on page 661, Dr. Guy Neff and colleagues review the costs associated with cirrhosis and discuss the cost-effectiveness of various preventative strategies. For example, hepatitis B virus (HBV) vaccination is cost-effective in many populations, as it can prevent HBV infection and the cirrhosis that might otherwise ensue. Likewise, antiviral treatment of hepatitis C virus (HCV) infection can also be cost-effective, as suppression of HCV infection can slow or halt progression to cirrhosis. Unfortunately, alcoholic liver disease—the third main cause of cirrhosis—cannot be easily treated. Abstinence from alcohol can reduce the risk of cirrhosis, but many

patients continue to consume alcohol despite knowledge of the risks, and interventions to improve alcohol abstinence are often ineffective.

While this information can help clinicians to select treatments that are both medically effective and cost-effective, more data are needed regarding cost-effectiveness of various interventions and treatment strategies. For example, Dr. Neff and coauthors mention that questions remain about the cost-effectiveness of allocating organs based on Model for End-Stage Liver Disease scores. While this system may improve survival for the sickest patients, it requires patients with only mild or moderate liver dysfunction to spend more time on the waiting list prior to transplantation, resulting in increased costs during this period. Future studies will hopefully shed more light on this issue and other outstanding questions.

In the rest of this month’s issue, we have a review article describing factors that predict aggressive inflammatory bowel disease, as well as columns covering several interesting topics: a comparison of cyclosporine versus infliximab for the treatment of severe ulcerative colitis, an overview of how imaging studies can be used to aid in the diagnosis of benign liver tumors, a discussion of the degree-of-difficulty scale for endoscopic retrograde cholangiopancreatography procedures, and an examination of the relationship between Barrett esophagus and patients’ life expectancy. We also have 2 interesting case studies, one on liver injury induced by the Japanese herbal drug kamishoyosan and another describing a metastasis of renal cell carcinoma that was found in the pancreas 13 years postnephrectomy. As always, I hope this information proves both interesting and relevant.

Finally, I would like to invite readers to submit original research articles for future publication in *Gastroenterology & Hepatology*. Clinical studies, meta-analyses, or other original reports are welcome. All articles will be peer-reviewed, and accepted manuscripts will be included in upcoming issues of the journal, which is distributed to over 16,000 readers. Articles will also be indexed through PubMed, PubMed Central, and EMBASE.

Sincerely,

A handwritten signature in black ink that reads "Gary R. Lichtenstein". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Gary R. Lichtenstein, MD, AGAF, FACP, FACG