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EDITORIAL COMMENT

In “National trends in the utilization of androgen deprivation therapy for very low risk prostate cancer,” the authors demonstrate a significant decline in the use of primary androgen deprivation (pADT), for very low risk prostate cancer. By 2015, only 1.7% of men in this population received pADT, representing a furthering of trends witnessed in the early 21st century, and which have been previously described.^{1,2}

In an era where so little pADT is being administered, it is important to remember the well-documented public health crisis of pADT overuse in the 90s and early 2000s. By the year 2000, up to 20% of intermediate-risk and 14% of low-risk PCa patients were receiving pADT, forgoing definitive intervention for a treatment with almost no evidentiary basis.³ While numerous factors drove these treatment decisions, it would be foolish to overlook the role of big pharma in misleading physician behavior.

In the year 1997, over 14,000 urologists administered Lupron to prostate cancer patients insured by Medicare, accounting for \$504 million in payments (mean \$36,000 per urologist); the top 25 urologists received \$41.2 million of the Medicare reimbursements, accounting for a mean of \$1.6 million per urologist.

In a 2001 settlement between the United States and the makers of Lupron, the US Attorney for the case indicated “inducements to physicians included free products; free consulting services; trips to expensive golf and ski resorts; money disguised as ‘educational grants,’ but in fact was used and intended to be used for many purposes, including cocktail party bar tabs, office Christmas parties, medical equipment, travel expenses. . . .” The result of this 2001 settlement included the largest (up to that time) fine for Medicare fraud of \$559.5 million. The settlement also directly named 4 urologists who had been charged (and plead guilty) to healthcare fraud.⁴

Subsequently, 2 concomitant phenomena were associated with decreasing rates of inappropriate pADT.²

1-CMS modified the reimbursement model for in-office administered medications.⁵ Two numerous observational studies highlighted the potential dangers of ADT including cognitive side effects, metabolic derangement, and cardiovascular mortality.^{6-8,9}

The story of the rise and fall of inappropriate ADT monotherapy highlights several important points that relate to the current manuscript, including the very appropriate response of the urologic community (vis-à-vis decreasing use of ADT monotherapy) as evidence of the harms of ADT monotherapy and its lack of efficacy surfaced. With the passage of time, this saga runs the risk of being forgotten, and few urologists entering the work force are familiar with a very important episode in urologic history. Furthermore, it is critical to remember this history, lest we be doomed to repeat it (think opioid crisis).

Finally, this episode in urologic history highlights the important role that well-designed observational studies can have in driving health policy and in promoting patient health.

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