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With so many unanswered questions on patient safety, it is difficult for researchers to know where to start. David Bates and colleagues describe their attempt to identify the priorities

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US residents with insurance are spending more of their incomes on health care than ever before, p 1234

CAREER FOCUS PLUS JOBS AND COURSES START AFTER P 1278
Use of blood pressure lowering drugs in the prevention of cardiovascular disease: meta-analysis of 147 randomised trials in the context of expectations from prospective epidemiological studies

Use of any of the main classes of drugs to lower systolic blood pressure by 10 mm Hg or diastolic blood pressure by 5 mm Hg was found to reduce coronary events and, separately, heart failure by about a quarter, and stroke by about a third.

M R Law, J K Morris, N J Wald

Effect of virtual reality training on laparoscopic surgery: randomised controlled trial

With simulator training in this small Danish trial novices’ performance was significantly increased to that of intermediately experienced laparoscopists and real operation times were halved.

Christian R Larsen, Jette L Soerensen, Teodor P Grantcharov, Torur Dalsgaard, Lars Schouenborg, Christian Ottosen, Torben V Schroeder, Bent S Oettesen

Reporting of sample size calculation in randomised controlled trials: review

Adequate sample sizes are crucial in randomised trials, but a survey of recently published papers finds the calculations sample sizes are based on are often wrong.

Pierre Charles, Bruno Giraudou, Agnes Dechartres, Gabriel Baron, Philippe Ravaud

Long term monitoring in patients receiving treatment to lower blood pressure: analysis of data from placebo controlled randomised controlled trial

Six monthly measurement of blood pressure is too frequent and highly unlikely to show true treatment failure, according to this analysis of the perindopril versus indapamide arm of the PROGRESS trial in patients who had had stroke or transient ischaemic attack.

Katherine Keenan, Andrew Hayen, Bruce C Neal, Les Irwig

Prevalence of severe congenital heart disease after folic acid fortification of grain products: time trend analysis in Quebec, Canada

There was no annual change in the birth prevalence of severe heart defects before fortification but there was a significant 6% annual decrease afterwards, supporting previous evidence that periconceptual folic acid intake is preventive.

Raluca Ionescu-Ittu, Ariane J Marelli, Andrew S Mackie, Louise Pilote

Prehospital management of severe traumatic brain injury

Clare L Hammell, J D Henning

Diagnosis in general practice: Chronic cough in adults

This case is an example of how “test of treatment” can be used when the diagnosis is uncertain.

Kevin Barracough

Diagnosis in general practice: Diagnosis using “test of treatment”

Tests of treatment are commonly used when the diagnosis is uncertain, but can have pitfalls. The accompanying article gives an example of how test of treatment can be used.

Paul Glasziou, Peter Rose, Carl Heneghan, John Balla

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The deadline is 30 September 2009 and the winning article will be published in this year’s Christmas BMJ.
0.8% Proportion of 11-15 year olds who described themselves as being completely unhappy (Editorial, p 1222)

£394 million Amount saved in 2008 through cost effective prescribing (News, p 1230)

6.2% Decrease in the birth prevalence of severe congenital heart defects following mandatory fortification of grain products with folic acid (Research, p 1261)

11 000 Estimated number of people per year who sustain a severe traumatic brain injury (Clinical Review, p 1262)

8 weeks Minimum length of cough for a diagnosis of chronic cough (Practice, p 1267)

PICTURE OF THE WEEK
A convoy of Pakistanis heads away from military operations against Taliban guerrillas in the Odi Gram area of Pakistan’s troubled Swat valley. Nearly one million people have fled the conflict in the country’s north west, according to the United Nations (see news, p 1235).
A new era for blood pressure management

This week we publish two studies that, taken together, may herald a new era of blood pressure management. So say our editorialists Richard McManus and Jonathan Mant (p 1219). The studies challenge the current orthodoxy, which is still that antihypertensive treatment should be titrated against regular blood pressure measurements. If acted on, these studies will simplify how we manage cardiovascular risk, with antihypertensive treatment being offered regardless of blood pressure, with less frequent blood pressure monitoring, and with checking for adverse events as the main focus of medical care.

The first paper, by Malcolm Law and colleagues, represents an enormous amount of work (p 1245). The authors looked at data from 147 trials of antihypertensive treatment published between 1966 and 2007 involving 464 000 people aged 60-69. Their aim was to address the continuing uncertainty about which drugs to use and who to treat. They found that any one of the main classes of drug at standard dose reduced the incidence of fatal and non-fatal myocardial infarction by about a quarter and stroke by about a third. These reductions were similar in people with and without clinical cardiovascular disease and regardless of blood pressure before treatment. All classes of antihypertensive had a similar effect for a given reduction in blood pressure.

Two of the authors, Malcolm Law and Nick Wald, proposed the “polypill” (combining a statin, three antihypertensives at half standard dose, folic acid, and aspirin) in the BMJ six years ago as “a strategy to reduce cardiovascular disease by more than 80%” (BMJ 2003;326:1419). In their new paper they find some indirect support for the polypill concept. They discuss how combining their new results with two previously published studies shows that three antihypertensive drugs together, each at a low dose to minimise side effects, could increase the preventive effect, reducing heart attacks by about 45% and stroke by about 60%.

As McManus and Mant say, if antihypertensives differ little in their efficacy, then acceptability in terms of adverse effects becomes the key driver in deciding which drugs to use. And given the findings of our other blood pressure paper this week, acceptability rather than blood pressure itself becomes the main focus of medical checkups, which may be needed much less often than currently supposed. Katherine Keenan and colleagues (p 1260) sought to differentiate true changes in blood pressure over time from random variation and measurement “noise”. Using data from the treatment arm of a randomised trial of long term antihypertensive drugs in people who had had a stroke or transient ischaemic attack, they found that when a patient’s blood pressure was seen to exceed treatment thresholds this was most likely to be due to day to day variability rather than to true increases in blood pressure.

In the UK, general practitioners are currently paid to ensure that their patients’ blood pressures have been checked in the past nine months. If such checks are not only costly in terms of patients’ and doctors’ time but also likely to give unreliable information, how soon can we change the policy?

Fiona Godlee, editor, fgodlee@bmj.com

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