BMJ 2015;351:h4446 doi: 10.1136/bmj.h4446 (Published 18 August 2015)

LETTERS

INTRACRANIAL HAEMORRHAGE, ANTIDEPRESSANTS, AND NSAIDS

Authors' reply to Lewis and Bray

Stewart W Mercer *professor of primary care research*[1], Rupert A Payne *National Institute for Health Research clinical lecturer*[2], Barbara I Nicholl *lecturer*[1], Jill Morrison *professor of general practice*[1]

[1]General Practice and Primary Care, Institute of Health and Wellbeing, University of Glasgow, Glasgow G12 9LX, UK; [2]Primary Care Unit, Institute of Public Health, University of Cambridge, Cambridge, UK

We were interested to read the rapid responses to our editorial about Shin and colleagues' paper.[1 2] We stand by our statement about the difficulty of making evidence based decisions in patients with multiple comorbidities in general practice, for whom high quality scientific evidence is almost always lacking. And, although we agree with Lewis that computer alerts bombard GPs when attempting to prescribe drugs, therein lies the problem.[3] These alerts occur so often that they lead to "alert fatigue," with GPs not checking most prescriptions that lead to an alert.[4] Even when GPs do check the prescription, they still have to decide whether the drug's benefits outweigh potential risks for the individual patient. The information needed to calculate the risks is not provided with the alerts and GPs have little time to search for the evidence during brief consultations, provided that evidence exists and is applicable to that particular patient.

Furthermore, evidence about risk is unlikely to be available from studies for five, six, or more drugs used in combination. In one Scottish study, more than 20% of patients were prescribed five or more drugs.[5]

We agree with Bray that it would have been helpful if Shin and colleagues had included the risk of non-steroidal anti-inflammatory drugs alone because, as we stated in our editorial, the risk of intracranial bleeding associated with these drugs individually remains unclear and cannot be definitely attributed to a drug interaction.[6] However, we think it is likely that, if the risk with an individual drug class is higher than the combined risk reported by Shin and colleagues, this would have been noted in previous studies.

Competing interests: None declared.

1 Mercer SW, Payne RA, Nicholl BI, et al. Risk of intracranial haemorrhage linked to co-treatment with antidepressants and NSAIDs. *BMJ* 2015;351:h3745. (14 July.)
2 Shin J-Y, Park M-J, Lee SH, et al. Risk of intracranial haemorrhage in antidepressant users with concurrent use of non-steroidal anti-inflammatory drugs: nationwide propensity score matched study. *BMJ* 2015;351:h3517. (14 July.)
3 Lewis LS. Combined use of antidepressants and NSAIDs: NNT for intracranial haemorrhage. *BMJ* 2015;351:h4444.
4 Hayward J, Thomson F, Milne H et al. "Too much, too late": mixed methods multi-channel video recording study of computerized decision support systems and GP prescribing. *J Am Med Inform Assoc* 2013;20:e71-84.
5 Guthrie B, Makubate B, Hernandez-Santiago V, et al. The rising tide of polypharmacy and drug-drug interactions: population database analysis 1995-2010. *BMC Med* 2015;13:74.
6 Bray BD. Study design cannot support link between intracranial haemorrhage, antidepressants, and NSAIDs. *BMJ* 2015;351:h4445.

Cite this as: *BMJ* 2015;351:h4446

stewart.mercer@glasgow.ac.uk