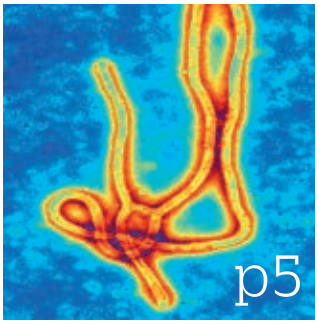
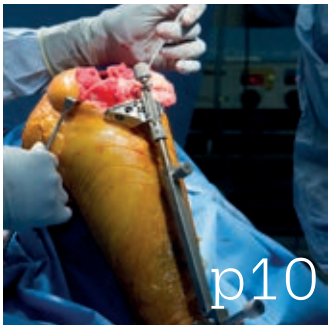
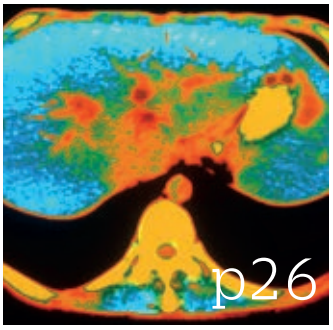
THIS WEEK

Articles appearing in this print journal have already been published on thebmj.com, and the print version may have been shortened







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The BMJ website is fully responsive, which means that its pages automatically fit the different screen sizes of desktop and laptop computers, tablet devices, and smartphones.

The new design is also less cluttered, which should mean that browsing is easier and pages load faster, with more prominent links to *The BMJ*'s campaigns, investigations, and advice for authors.

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WELLCOME COLLECTION

PICTURE OF THE WEEK

"Z for Zoonoses." A 1907 model of Henry Wellcome's floating research laboratory, which was used to research zoonoses in otherwise inaccessible areas along the Nile river. The model is part of the exhibition "An Idiosyncratic A to Z of the Human Condition," which is on display at the Wellcome Collection, London, until 12 October.

RESPONSE OF THE WEEK

The poor survival figures for UK cancer patients are an embarrassment to the government.

GPs know that the 2 week rule will be overwhelmed if we refer every patient at first presentation of any symptom that could possible be cancer. We GPs are caught in a trap where we, on the one hand, must not be seen by our peers to be over referring yet, on the other, are expected not to miss early cancer presentation. Even the 2 week red flag symptoms usually restrict referrals by patient age and include such things as weight loss—surely a symptom that things are already well advanced.

GPs are thus the risk sinks of the NHS. Much better for the government to imply poor clinical judgement by GPs for our poor survival figures than government underfunding.

So until morale improves, the beatings will continue.

Peter John O'Donnell, retired GP, Epsom, UK, in response to, "Jeremy Hunt's bizarre ideas show that he doesn't understand general practice"
(*BMJ* 2014;349:g4368)

MOST READ

- Mass treatment with statins
- Dabigatran: how the drug company withheld important analyses
- The epidemic of pre-diabetes: the medicine and the politics
- Fruit and vegetable consumption and mortality from all causes, cardiovascular disease, and cancer
- Evidence based medicine: a movement in crisis?

THEBMJ.COM POLL

Last week's poll asked:
Should GPs prescribe statins for primary prevention of cardiovascular disease?

63% **voted no** (total 117 votes cast)

BMJ 2014;349:g4386

This week's poll asks:
Should patients with Ebola have the chance to try experimental drugs?

Feature: *BMJ* 2014;349:g4997

News: *BMJ* 2014;349:g5103

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EDITOR'S CHOICE

Too much information

Organisations providing information should document the levels of evidence that link the adverse effect with the drug

It's hard to escape discussing the benefits and harms of drug treatments in a clinical medical journal, and this week is no exception.

Kirin Tan and colleagues (p 15) ask how helpful is the information provided to patients about possible adverse drug reactions. They conclude that it is excessive, inconsistent, often poorly presented, and overwhelmed by symptoms commonly experienced in daily life.

Using data from a recent population based survey published in *BMJ Open* (2014-005374), they list 20 symptoms most commonly reported in the previous seven days, such as back pain, fatigue, and headache. Nine of these are listed in more than half of the drug information documents they reviewed, and eight are listed as an adverse reaction to more than 90% of the drugs they looked at.

What should patients make of this? The authors fear that so many possible harms will deter patients from starting or continuing treatments, or might raise negative expectations and increase rates of reporting of adverse events (the nocebo effect). At the very least, they say, organisations providing information should document the levels of evidence that link the adverse effect with the drug, and where possible provide numerical estimates of risk. They also say that greater reliance should be placed on randomised rather than observational data, except where adverse events are serious or rare. This apparently uncontroversial suggestion will, I have no doubt, raise hackles among those who question the ability of randomised trials to properly report adverse events.

More controversially still, they suggest that clinicians should "contextualise" the information they provide to patients, toning down discussion of common non-specific symptoms to reduce the nocebo effect. They acknowledge that this might be considered patronising but consider this worth the risk for better adherence to effective treatments.

What I don't see in the paper is any discussion of the role of patient preferences. But this absence reflects much of medicine. And things would be easier if we had better evidence, so that rather than hide information that we believe is unreliable, we could confidently share all the information we have.

Certainly the evidence on which a new steroid formulation has been licensed does nothing to inspire confidence. As Anjali Amin and colleagues explain (p 6), a modified release hydrocortisone was approved on the basis of a single non-blinded crossover trial in 64 patients, in which the comparative doses were not equivalent. The authors recommend sticking to the old faithful thrice daily hydrocortisone, or better and cheaper still, once daily prednisolone.

As for tranexamic acid, things are looking good. Jashvant Poeran and colleagues' retrospective study found that it reduced bleeding after elective orthopaedic surgery without increasing rates of thromboembolism and while reducing rates of perioperative myocardial infarction (p 10). Our editorialists are optimistic (p 7) but they suggest we wait for a properly powered randomised controlled trial before breaking out the champagne.

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