represents the first time that WHO has used its constitutional authority to develop a legal instrument for improving health. Drawing on scientific evidence, the convention includes measures relating to reducing the demand for tobacco (price and tax measures, restrictions on tobacco advertising) and the supply of tobacco (restriction of sales to minors, economically viable alternatives for growers). The authors state that these interventions could reduce the global burden of disease attributable to tobacco by up to 60%.

POEM*

Oral clindamycin for asymptomatic bacterial vaginosis in early pregnancy reduces premature births

Question Does treatment with oral clindamycin for bacterial vaginosis before 22 weeks' gestation lead to decreased premature births and late miscarriages?

Synopsis Previous studies of screening for bacterial vaginosis in pregnancy performed the screening late in the second trimester and treated bacterial vaginosis with metronidazole. In this randomised controlled double blinded trial, a general population of 6120 asymptomatic pregnant women in the United Kingdom was screened in antenatal outpatients for bacterial vaginosis by using Gram stain and Nugent scoring (0-10), and 494 (8.1%) women positive for bacterial vaginosis with a Nugent score higher than 3 who were randomised (allocation concealed) to oral clindamycin 300 mg twice a day for five days (n = 249) or placebo (n = 245). By chance the treated group had a history of fewer miscarriages (26% *v* 34%) but not fewer preterm deliveries (10% *v* 9%). Spontaneous preterm deliveries (24-37 weeks' gestation) were 11/244 (5%) in the treated group versus 28/241 (12%) in the placebo group, and late miscarriages (13-24 weeks) were 2/244 (1%) compared with 10/241 (4%) (P = 0.001 for the combined end point; number needed to treat = 10). The number needed to screen to prevent one preterm birth or late miscarriage was approximately 120. There were no differences in mean birth weight, low birth weight, stillbirths, or mean gestational age at delivery. There was a trend to increased gastrointestinal side effects in the treated group (7% *v* 3%; P = 0.10). Admissions to neonatal intensive care were 8% in the clindamycin group compared with 10% in the placebo group (P = 0.41), which would be clinically significant if the study had been large enough to show a statistically significant difference.

Bottom line Women with asymptomatic bacterial vaginosis who were treated with oral clindamycin before 22 weeks' gestation had fewer second trimester miscarriages and preterm births, with a number needed to treat of 10. The study was not large enough to show a difference in neonatal admissions to intensive care units. The Gram stain screening method and generic antibiotic treatment are simple and inexpensive. The potential here for getting a big bang for a buck in our use of healthcare dollars is very attractive. Previous studies using metronidazole and treatment at later gestational age have not found screening to be beneficial. This study needs to be replicated in a larger trial before introducing widespread screening for bacterial vaginosis in pregnancy.

Level of evidence 1b (see www.infopoems.com/resources/levels.html); individual randomised controlled trials (with narrow confidence interval).

Ugwumadu A, Manyonda I, Reid F, Hay P. Effect of early oral clindamycin on late miscarriage and preterm delivery in asymptomatic women with abnormal vaginal flora and bacterial vaginosis: a randomised trial. *Lancet* 2003;361:983-8.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

The pleasures of deep reading

The competitors of the *BMJ* include Hollywood films, Manchester United, and a walk in the park. We live in the "attention economy" and compete desperately for a few moments of your time. There are so many other things to do apart from read the *BMJ*. Consequently many readers spend only a few minutes on the journal, flicking from Minerva to the news and checking the obituaries (as a very old joke has it) to see they are not there. But there is much insight—and even pleasure—to be had from reading articles slowly, savouring every thought, word, and nuance. This issue has at least two examples.

John Iredale has spent over 13 years studying mechanisms of fibrosis in cirrhosis and shares his insights into how it may eventually be possible to treat the underlying fibrotic process and reverse the disease (p 143). Hepatic stellate cells seem to mediate the final common pathway of fibrosis. They are activated in liver injury and transform into cells that produce fibrillar collagen. Much research concentrates on what activates the cells and how activation might be blocked or turned off.

But most patients who present with cirrhosis already have extensive fibrosis. Could the fibrosis be reversed? It seems that the collagen rich matrix produced during fibrosis is dynamic, and it may be possible to encourage degradation of the matrix by blocking the tissue inhibitors of metalloproteinases, which themselves block the degradation that would otherwise be occurring. If the matrix is degraded then normal (or near normal) liver architecture can return. Another way to reverse fibrosis might be to encourage the hepatic stellate cells to move into apoptosis, cell suicide.

Edward Shorter and Peter Tyrer use very different methods—illustrating in passing why medicine is so interesting—to consider why it might be that new drugs for mood and anxiety disorders dried up in the 1990s (p 159). They think that the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) is part of the problem. Published in 1980, it created a "firewall" between anxiety and depression, making them "as different as chalk and cheese." This is unhelpful, Shorter and Tyrer argue, because the commonest form of affective disorder is mixed anxiety-depression, and the subdivision of anxiety into separate microdiagnoses is questionable.

The pharmaceutical industry has heavily influenced the classification of these disorders because "every new diagnosis represents a new licensing opportunity … Each new anxiety diagnosis seems to create an opportunity for a phoney new drug indication … paroxetine for social anxiety disorder, fluvoxamine for obsessive compulsive disorder, and sertraline for post-traumatic stress disorder." Perhaps—as the *BMJ* argued for female sexual disorder (2003;326:45)—the companies find it easier to create new diseases than new drugs. The authors advise that "companies must start developing drugs for mixed anxiety and depression and forget about dividing this giant illness segment into salami slices."

Richard Smith *editor*