Heart attack patients need better secondary prevention

Even though secondary prevention after acute myocardial infarction reduces the risk of recurrence and death, its implementation remains suboptimal. On page 693 Dalal and colleagues describe drug and other treatments available after myocardial infarction.

Antiplatelet drugs, statins, angiotensin converting enzyme inhibitors, and β blockers are the four main prophylactic drugs. Organisation of care and nurse led clinics for secondary prevention, cardiac rehabilitation, and smoking cessation may improve outcomes, but not all patients receive all the treatment they need. Up to 20% of patients are depressed after myocardial infarction, and this is associated with increased mortality.

POEM*

Tamsulosin is effective for renal colic

Question Is tamsulosin (Flomax) useful in the treatment of renal colic?

Synopsis The medical management of renal colic secondary to stone retention includes the reduction of ureteral oedema and spasm and the prevention of co-infection. $\alpha 1$ adrenergic antagonists reduce ureteral contractions and spasm and may hasten the passage of retained stones. A total of 163 patients presenting to an emergency room in Italy with renal colic were identified; of these, 70 were found on imaging studies to have unilateral, juxtavesical ureteral stones. Ten were excluded for various reasons, including renal colic for more than one day. The remaining 60 patients were randomised (non-concealed allocation assignment) to two groups. Group 1 received 30 mg deflazacort (a corticosteroid to control oedema) daily, cotrimoxazole (a prophylactic antibiotic) twice daily, 75 mg injectable diclofenac (Voltaren) on demand, and floriglucine-trimetossibenzene (a local spasmolytic drug) thrice daily. Group 2 received similar treatment with the substitution of 0.4 mg of tamsulosin (Flomax) as the spasmolytic drug. All patients were instructed to drink a lot of water. The patients, their treating clinicians, and individuals assessing outcomes were not blinded to treatment group assignment (a big methodological no-no). The mean stone size was 5.8 mm (range 4 mm to 11 mm). Although the mean stone size was statistically larger in group 2, the expulsion rate was greater than in group 1 (100% v 70%; $P=0.001$; number needed to treat = 3). In addition, the mean hours to expulsion, the mean number of diclofenac injections, the rate of hospitalisation, and the need for endoscopic stone removal were all lower in the tamsulosin group. Although not specifically stated, it seems that analysis was by intention to treat.

Bottom line Even though this study is fraught with methodological shortcomings, it seems highly likely that tamsulosin (Flomax) is effective in hastening the passage of juxtavesical ureteral stones and decreasing both the severity and duration of renal colic.

Level of evidence 2b (see www.infoPOEMs.com/levels.html). Individual cohort study or low quality randomised controlled trials (80% follow up)

Dellabella M, Milanese G, Muzzonigro G. Efficacy of tamsulosin in the medical management of juxtavesical ureteral stones. *J Urology* 2003;170:2202-5.

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

Editor's choice

Why are we complacent about alcohol?

Twenty years ago I was a firebrand on firewater. I wrote rabid articles in the *BMJ* describing the dramatic range and extent of damage from alcohol and considering the options for responding. If the media wanted an anti-alcohol campaigner I was one of their first choices. I ranted and raved, and one unintended consequence was that I became friends with many wine writers and got to taste some exquisite vintage claret and 100 year old calvados. Now an old colleague in the battle against drink writes to ask me what went wrong. Why when things have got worse not better am I silent on the issue? The more important question, I think, is why are we as a society so complacent about alcohol. The two questions have similar answers.

The answers are topical because the British government has just produced its strategy for reducing harm from alcohol (p 659). It's the dampest of squibs. Any government that was serious about reducing alcohol problems would increase the price of alcohol. It's the one measure that will reliably reduce harm. And yet, as the Academy of Medical Sciences showed in its recent report (6 March, p 542), the price in Britain has fallen and consumption and damage have increased. Education, controls on advertising, and partnerships with the drinks industry are so much flim flam.

Why then are we all so complacent? One reason is that it's our favourite drug. Most people in England drink, and many of us—including prime ministers, journalists, judges, doctors, policy pundits, and medical journal editors—like to stack it away. Righteous indignation about ecstasy is easy because we don't use it and don't want to.

For politicians there is the important problem of a million jobs, tax revenues, and exports. There are few votes in being serious about alcohol problems—and those there are have to do with drunks vomiting on people's lawns. And the political power of the drinks lobby is huge, far beyond that of a row of doctors wringing their hands. Hence, Tony Blair starts his foreword to a strategy to reduce harm by writing: "Millions of us enjoy drinking alcohol with few, if any, ill effects. Indeed, moderate drinking can bring some health benefits." So, what's the problem, Tony? His first answer is "antisocial behaviour in towns and city centres."

Another cause of complacency is that a little alcohol—and maybe even quite a lot—does seem to help you live longer. This fact leads to confusion over the message. Is it drink less, drink sensibly, drink like me? And what is sensible drinking? Is there something not sensible about my daily wine with dinner—and maybe Lagavulin later? I can't believe that: I'm not being sick over anybody.

Finally, it's too easy to be defeatist. Dozens of reports have produced no improvement. In contrast, we've made progress with smoking—because even those who smoke want to stop.

Richard Smith *editor rsmith@bmj.com*

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