One question improves diagnosing depression in primary care

Adding a question (about whether the patient wants immediate help with depressive symptoms) to two screening questions for depression in general practice improves the specificity of the screening. Arroll and colleagues (p 884) report on a cross sectional diagnostic validity study that included 19 general practitioners and more than 1000 consecutive patients in six clinics in New Zealand. Using the two screening questions and the additional help question, general practitioners correctly diagnosed 79% of people with major depression and correctly assessed 94% of those without major depression.

How to use indirect evidence on multiple treatments

On p 897 Caldwell and colleagues describe the process, with examples, for deciding what is the best treatment for a condition when three or more possible treatments are available. Large, high quality randomised trials of all available treatments are rare; most trials, and hence meta-analyses, are pair-wise, using placebo or current treatment as comparators. Thus, the need exists to develop reliable methods for incorporating indirect evidence into policy making. The authors claim that statistical methods are available for combining direct and indirect evidence and that these should be more widely used to compare multiple treatments.

POEM*

Low dose aspirin doesn't lower women's cancer risk

Question Is low dose aspirin effective in reducing the risk of cancer among healthy women?

Synopsis Observational trials suggest that aspirin may be effective in preventing cancer. In the women's health study, the investigators randomised (concealed allocation assignment) 39 876 healthy women aged 45 or older to receive either aspirin 100 mg every other day or placebo. Individuals blinded to treatment assignment assessed outcomes. Follow-up occurred for an average of 10.1 years for more than 97% of the subjects. On intention to treat analysis, aspirin did not significantly reduce the incidence of any cancer, including breast, colorectal, and lung. There was no reduction in cancer mortality either overall or by site, except for lung cancer mortality (number needed to treat for 10 years = 800). All cause mortality was also not reduced by aspirin.

Bottom line Low dose aspirin does not reduce the risk of lung, breast, colorectal, or other site cancer in healthy women aged 45 years and older. There may be a protective effect on reducing lung cancer mortality, but overall mortality is not reduced.

Level of evidence 1b (see www.infoPOEMs.com/levels.html). Individual randomised controlled trials (with narrow confidence interval).

Cook NR, Lee IM, Gaziano JM, et al. Low-dose aspirin in the primary prevention of cancer. The women's health study: a randomized controlled trial. *JAMA* 2005;294:47-55.

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

Editor's choice

Keep politics out of it

Are complementary and alternative medicines cost effective? Patients are increasingly voting with their feet, despite having to pay out of their own pockets, so governments and health plans must decide whether these treatments should be provided alongside conventional health care. The much leaked and now somewhat improved Smallwood report concludes that they should be funded, arguing that they will help patients and save money. In their editorial (p 856) Trevor Thompson and Gene Feder are perplexed about some aspects of the report—in particular the inclusion of asthma as one of the “effectiveness gaps” of conventional medicine. But overall they conclude that complementary medicine should be included in clinical guidelines despite limited evidence of cost effectiveness.

As an example of how poor the evidence is, Peter Canter and colleagues present a systematic review of cost effectiveness analyses of complementary treatments (p 880). They found only five rigorous analyses, one of acupuncture and four of spinal manipulation. They conclude that these treatments are an additional cost to usual care, with uncertain clinical benefit.

If the evidence for older medicines remains thin, biotechnology is not faring any better. Recombinant DNA and other techniques were set to provide us with cheaper and better treatments, but Roberta Joppi and colleagues found that few biotech products on the market have been rigorously evaluated (p 895). They reviewed 61 substances licensed by the European Medicines Evaluation Agency. Most turned out to be variations on existing drugs rather than true therapeutic innovations and were generally more expensive than the non-biotech alternatives.

Meanwhile, a class of drug that had a cloud over it gets a reprieve this week. A *BMJ* editorial concluded last year that angiotensin receptor blockers were not obviously superior to ACE inhibitors in people at high risk of cardiovascular events and that they may increase the risk of myocardial infarction. This week we publish a systematic review by Michael McDonald and colleagues which finds no evidence of increased risk (p 873). This fits recent trial findings that drugs acting on the renin-angiotensin system provide better control of blood pressure and result in fewer deaths and less diabetes than older antihypertensive regimens (p 859).

For those trying to decide between one of several treatments, Deborah Caldwell and colleagues show how to do this without relying on indirect comparisons (p 897). However we make these decisions, one thing is clear—politics should not come into it. Frank Davidoff, a former editor of *Annals of Internal Medicine*, has resigned as an adviser to the US Food and Drug Administration because of the way it postponed a decision on over the counter sales of emergency contraception: “Flagrantly,” he says, “on the basis of political influence rather than scientific and clinical evidence” (p 861). And we should all be concerned that the UK's health secretary, Patricia Hewitt, sees it as within her gift to allow women with breast cancer to be tested for treatment with the new wonder drug trastuzumab (Herceptin). Aren't decisions like that what arm's length evaluators like NICE are for?

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