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This week in the BMJ

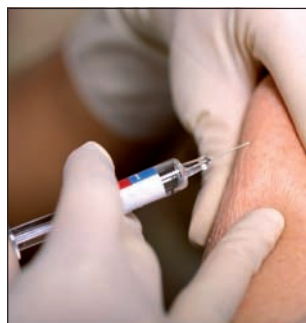
Antibiotic prevents complications of measles



PHILIPPO

Prophylactic co-trimoxazole given to children with measles reduces the incidence of pneumonia (odds ratio 0.08, 95% confidence interval 0 to 0.56) and conjunctivitis, and positively affects weight gain in the month after infection ($P = 0.04$), say Garly and colleagues (p 1245). They randomised 84 patients in Guinea-Bissau with measles to receive either the antibiotic or a placebo for seven days after diagnosis. They found no difference in rates of otitis media between groups. The authors recommend the use of prophylactic antibiotics in measles in low income countries.

Flu vaccine for staff protects care home residents

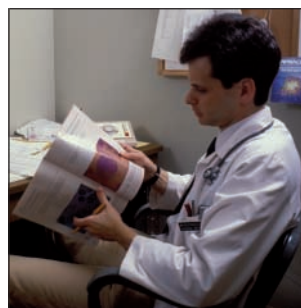


LEA PATTERSON/SPL

Vaccinating care home staff against influenza in times of moderate influenza activity

can reduce deaths, health service use, and hospital admissions in residents, say Hayward and colleagues (p 1241). The authors randomised 44 care homes in the United Kingdom to offering their staff influenza vaccine or not for two consecutive winters. In the first winter, when influenza activity was high, vaccination had a significant positive impact on residents' health; but this was not seen the next winter when influenza rates were lower than usual.

Journals omit absolute risks

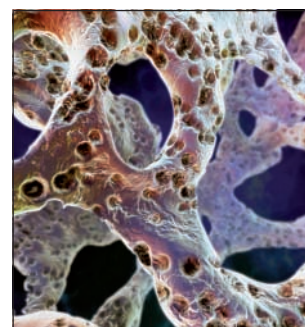


PHOTOFEST INC/ALAMY

Absolute risks should be routinely included in abstracts, adjacent to any reported risk ratio, to allow readers to discern the meaning of ratio measures. In a structured review of the accessibility of absolute risk data in six leading journals, including the *BMJ*, Schwartz and colleagues (p 1248) examined 222 articles with study designs that allow absolute risks to be calculated. They found 68% of articles failed to report absolute risks in the abstract, and half of these did not report them anywhere in the article.

How to manage osteoporosis

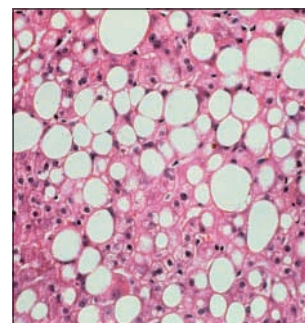
Considerable advances have been made in identifying people at risk of fractures because of osteoporosis and in treatments designed to reduce fractures, say Poole and Compston (p 1251) in their clinical review of the



HYBRID MEDICAL ANIMATION

management of osteoporosis. They discuss the genetic, nutritional, hormonal, and physical factors that influence peak bone mass, which is attained in the third decade and determines bone mineral density in later life. Avoidable clinical risk factors for fragility fractures include smoking, high alcohol consumption, low body mass index, and falls.

Lab tests for diabetic dyslipidaemia



BIOPHOTO ASSOCIATES/SPL

Hypertriglyceridaemia is commonly associated with poorly controlled diabetes and does not usually respond well to lipid lowering agents before hyperglycaemia is tackled, says Smellie (p 1257). In this Practice article the author examines two cases in which patients' serum biochemistry showed hypertriglyceridaemia that was difficult to treat in primary care because of diabetes. High triglyceride concentrations are associated with a risk of complications such as pancreatitis and fatty deposits in the liver. Management of such patients needs to incorporate lifestyle advice as well as drug therapy and ongoing monitoring.

Cardiovascular risk assessment for primary prevention is often inaccurate

Research question Are cardiovascular risk scores reliable?

Answer Not particularly. They can underestimate or overestimate true risk depending on the population under study

Why did the authors do the study? Risk scores, tables, and charts are widely used to predict an individual's risk of cardiovascular events such as heart attack. Knowing what might happen (and how likely it is) helps people change their behaviour, and helps doctors target preventive treatments at those most likely to benefit. These authors wanted to find out if commonly used risk scores are accurate. They also wanted to know if assigning a risk score helps prevent cardiovascular disease in the long term.

What did they do? They did two systematic reviews of the evidence. The first included 27 studies of the accuracy of cardiovascular risk scores in different populations ($n = 71\,727$). The second included four randomised controlled trials testing the impact of risk scoring on cardiovascular disease. The authors searched eight research databases for published studies in any language. They also hand searched reference lists and key journals, and chased the authors of selected articles for any missing data.

Both reviews were confined to studies of primary prevention—the use of risk scoring to predict and prevent disease in people with no disease at baseline. They were also confined to studies of widely used scores, tables, charts, and clinical decision tools based on the Framingham equation.

What did they find? In the first review, risk scores were not particularly good at predicting the absolute risk of coronary heart disease or cardiovascular events over 10 years. The scores tended to underestimate risk in the most vulnerable populations (such as those with diabetes or a family history of heart disease) and inflate risk in the least vulnerable populations. The ratio comparing the predicted risk of heart disease with the observed risk over 10 years varied between 0.43 (95% CI 0.27 to 0.67) for people with a family history of heart disease and 2.87 (1.91 to 4.31) for low risk German women.

The four trials in the second review were inconsistent. Two reported that assigning a cardiovascular risk score had a positive effect on patients' treatment, but only one reported a significant clinical effect (lower blood pressure). All the patients in these studies had diabetes (one trial) or hypertension (three trials).

What does it mean? Widely used risk scores aren't a particularly reliable way of predicting someone's long term risk of heart disease or cardiovascular disease, and there's no good evidence that risk assessment with the recommended tools helps improve treatments or prevent disease.

Charts, tables, and decision aids based on data from the Framingham study can either overestimate or underestimate true risk of heart disease depending on the population being assessed. This in turn could lead to overtreatment or undertreatment with drugs such as statins, antihypertensive agents, and aspirin.

Refining risk scores by including other risk factors, particularly poverty, might help. But even if scores can be better calibrated, there's still a long way to go before they can be considered safe and effective.

Brindle et al. Accuracy and impact of risk assessment in the primary prevention of cardiovascular disease: a systematic review. *Heart* 2006;92:1752-9

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Editor's choice

New beginnings

As the year comes to a close, so too does one of the *BMJ's* great institutions. This week we publish the last article in the last of our ABC series. ABCs first appeared in the *BMJ* in 1978—the brain child of the then editor, Stephen Lock. Over the years they have been praised and criticised in equal measure, and with the move of ABC books (part of BMJ Books) to Blackwell Publishing and the forthcoming relaunch of the *BMJ*, this seemed the right moment to stop our serialisations.

In their place we are creating a range of new series in the Practice section, aimed at helping to bridge the gap between primary and secondary care and between research and practice. We see this section as representing the “how” of medicine, the place in the journal where, as far as possible, our authors report on the areas of certainty in medicine, surgery, and public health. Readers will find respite here, should they wish it, from the debate, controversy, and uncertainty all around them.

The need for clear, impartial advice has never been greater, especially in the light of increasingly sophisticated drug company marketing, as delegates heard at last week's NICE conference (p 1239). Annette Tuffs reports that sponsorship of patient groups by drug companies is growing (p 1238), one medical society has been torn apart by concerns about industry influence (p 1240), and in an extraordinary case, a US federal researcher has admitted covertly selling clinical samples from the National Institutes of Health to Pfizer (p 1237).

What about interpreting the evidence? At the NICE conference, Neal Maskrey, medical director of the National Centre for Prescribing, is reported as saying that most general practitioners don't know what absolute risk is (p 1239). If he's right, medical journals must take part of the blame. According to Lisa Schwartz and colleagues, six major medical journals, including the *BMJ*, did a poor job in 2003-4 of reporting absolute risk in research articles, and especially in the abstract (p 1248). We ask for absolute event rates, relative risk reduction, and number needed to treat or harm in reports of clinical trials. Of the two trials in this week's *BMJ*, one gives this information in the abstract and the text (p 1245), the other only in the text (p 1241). So there's still room for improvement.

It's a little early for New Year's resolutions, but next week is our Christmas issue and after that it will be too late. Apart from doing better on reporting of trials, this week's journal has a couple of ideas. Julian Crane and Brent Caldwell have calculated the carbon footprint of the European Respiratory Society's annual congress (p 1256). The travel alone would require 784 000 trees to offset it. So how about we all travel far less and plant more trees? A moving rapid response from Anthony Read, a factory worker in Wallsend who was inspired by transplant pioneer Roy Taylor to donate a kidney to his brother (www.bmj.com/cgi/eletters/328/7440/646), reminds us all to thank the people we want to thank before they die.

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