NASA

improved by using new technologies and methods of health measurement, strengthening national capacity to collect and analyse health data, establishing global norms and standards, and creating and disseminating optimal information, argue Murray and colleagues (p 1096). They challenge the role of the World Health Organisation in this and propose an independent monitoring body.

POEM*

Omeprazole 20 mg = 40 mg for primary care acid related dyspepsia

Question Is 40 mg omeprazole more effective than 20 mg for primary care patients with dyspepsia?

Synopsis A common primary care strategy for patients with dyspepsia and no alarm symptoms is to prescribe a proton pump inhibitor. This pragmatic randomised controlled trial study took place in a Danish primary care research network with 103 participating physicians and 829 patients. Adults presenting with dyspepsia (that their physician thought was acid related) and no alarm symptoms were randomised to omeprazole 40 mg per day, omeprazole 20 mg per day, or placebo. Alarm symptoms were defined as rectal bleeding or haematemesis, unintended weight loss, vomiting, dysphagia, jaundice, or other signs of serious disease. Groups were similar at baseline, with a mean age of 50 years; 58% were women. Allocation was concealed and outcomes were blindly assessed, with analysis by intention to treat. Patients were treated for two weeks, and then medications were discontinued. During the remaining year of observation, in which 92% of the patients participated, the author tracked the time until relapse of symptoms and the consumption of healthcare resources. The most common symptoms in both groups were epigastric pain, regurgitation, heartburn, bloating, and pain at night. Symptoms were rated as moderate by 63% of patients and severe by 15%. At two weeks, sufficient relief was reported more often in the 40 mg and 20 mg groups than in the placebo group (71%, 69.6%, and 43%, respectively), as was complete relief (66.4%, 63%, and 34.9%). The number needed to treat was between 3 and 4 for both outcomes. Results were similar for Helicobacter pylori positive and *H pylori* negative patients. Most patients in all three groups had a relapse of symptoms during the year following their initial treatment.

Bottom line Omeprazole (Prilosec) 20 mg is highly effective for treating acid related dyspepsia. There was no advantage to higher doses, and relapse following the initial two week treatment period was common.

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

Meineche-Schmidt V. Empiric treatment with high and standard dose of omeprazole in general practice: 2-week randomized placebo-controlled trial and 12-month follow-up of healthcare consumption. *Am J Gastroenterol* 2004; 99:1050-8.

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

Editor's choice

Should journals mix medicine and politics?

Along with easy access to pornography, gambling (p 1055), and school friends who best remain forgotten, the internet has unleashed instant—and mass—complaint. This incredible people power makes publications instantly accountable. Why bother sending a written complaint or organising a paper petition when you can flood a website or an editor's inbox with cries of pain, anger, and sometimes vitriol? In addition to this welcome development bmj.com amplifies that criticism by posting electronic letters—we call them rapid responses—within 24 hours, provided they do not breach our rather laissez-faire rules of engagement (see bmj.com for rules).

We now encourage all readers to submit their letters electronically via our rapid response facility—it's easier than you might think—and select the best of these to publish in the print version of the *BMJ*. This week we publish a selection of responses to Derek Summerfield's personal view on the public health effects of Israel's security wall in the West Bank (*BMJ* 2004;329:924, 16 Oct), a view that triggered a deluge of initial complaints and then praise as both sides of the argument mobilised their wired up supporters (p 1101). Amid the hundreds of polarised opinions are a number of strong but constructive views, particularly from people with experience of the region, suggesting that a solution through dialogue not violence is possible.

For this dialogue to be meaningful, voices from both sides need to be heard, which is why we published Summerfield's view and why this issue carries a response from a doctor critical of Summerfield's opinion (p 1110). Both are powerful pieces, argued with emotion, and our personal view section is one that caters for strong opinion. It is inevitable that in a state of conflict those views will be sometimes abrasive and unpalatable. One way that the *BMJ* differs from many medical journals is that it offers a diverse mixture of articles. Many sections are rigorously peer reviewed, others are more journalistic—such as our news and reviews sections. Most of our readers understand and value this dichotomy.

Most of our readers also want us to reflect the entanglement of medicine and politics, according to a survey we conducted on bmj.com in 2002 (http://bmj.com/misc/politics.shtml). And the *BMJ* has traditionally published on broader social and political issues that affect health care. Indeed, a logical extension of the report by the Commission on Macroeconomics and Health in 2001 is that any issue has a health angle in the same way that the *Economist* has shown that any issue has an economic one. The *BMJ* will not shy away from difficult issues that impinge on health care. More so, medical journals have a duty to highlight concerns about abuses of state power—be they by the government of the United Kingdom, United States, China, Israel, or the Palestinian Authority. Medicine cannot exist in a political void.

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