19% in patients with CHD. The authors argue that the government should shift the focus of its policy from secondary prevention to primary prevention.

POEM*

Herpes zoster vaccine is safe and effective for older adults

Question Can a vaccine prevent herpes zoster and postherpetic neuralgia?

Synopsis Patients with herpes zoster (shingles) feel miserable, and postherpetic neuralgia—which complicates about 10% of cases—makes them feel even worse. This study identified people over 60 (47% were over 70) who had either a history of varicella or were presumed to have one because they had lived in the United States for at least 30 years. A total of 59% were men, 95% were white, and they had a generally good baseline health status. Patients were randomised (allocation concealed) to either 0.5 ml of live attenuated Oka/Merck varicella-zoster virus vaccine (n = 19 270) or placebo (n = 19 276). The vaccine is 14 times stronger than the vaccine used to prevent primary varicella infection in children. Groups were balanced at baseline and analysis was by intention to treat. Patients were followed for a median of 3.1 years, and 95% completed the study, which is excellent. The primary outcomes were the number of episodes of herpes zoster and postherpetic neuralgia; cases within 30 days of vaccination and second episodes were excluded. Fewer patients in the vaccination group developed herpes zoster (11.1 *v* 5.4 episodes per 1000 person years; $P < 0.001$; number needed to treat = 175 per year). Patients in the vaccinated group also had a somewhat shorter course (21 *v* 24 days; $P = 0.03$) and were less likely to develop postherpetic neuralgia (0.48 *v* 1.38 per 1000 person years; $P < 0.001$; NNT = 1111). The benefit was more pronounced in patients aged 60-69 than in older patients. Safety is an important issue in prevention studies since we are treating otherwise healthy patients. Safety was monitored in two ways: by patient's or physician's report for the entire population, and by diary entries for a subset of 6716 patients. For the entire study population, there was no difference in mortality between groups and no difference in possible vaccine-related adverse events, either during the first 42 days or for the duration of the three year study. For the group in a substudy of adverse events, one or more adverse events—primarily erythema, pain, swelling, or pruritus at the injection site—occurred more often during the first 42 days. As noted above, this is a higher potency vaccine; the vaccine currently used for children should not be used for adults.

Bottom line Herpes zoster vaccine is safe and effective for the prevention of herpes zoster and postherpetic neuralgia in older adults. The number needed to treat is quite large on an annual basis—even if the NNT of 1111 is linear for a 10 year period, 111 older patients would have to be vaccinated to prevent one case of postherpetic neuralgia during that period. The number needed to treat to prevent a case of herpes zoster is 175. Given the strength of this vaccination and the target population, long term follow-up studies are needed to identify any unexpected but serious complications that may appear down the road.

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

Oxman MN, Levin MJ, Johnson GR, et al, for the Shingles Prevention Study Group. A vaccine to prevent herpes zoster and postherpetic neuralgia in older adults. *N Engl J Med* 2005;352:2271-84.

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

Editor's choice

Stay at home

It's conference season again. The summer break is over and people all over the globe are leaping on planes and heading off to exotic, and not so exotic, locations to flit through windowless conference centres in anonymous air conditioned airport hotels, to give or watch or sleep through ever more elaborate PowerPoint presentations in darkened lecture halls. It's fun. It's traditional. But is it necessary? And is it good for us or the planet?

The terror threat might have given pause to some of us. But not for long. In the immediate aftermath of the London bombs, Rubin and colleagues found that people were slightly less willing to travel by tube and bus (p 606), but necessity breeds courage, or indifference, and international airlines continue to report record passenger numbers. US immigration controls may put off others, especially Muslim academics, says Gavin Yamey after his strange brush with the FBI at a conference last year (p 642).

And what about the impact of all this air travel on the environment? On p 643, a Dr B A Miles (alias Ian Roberts) confesses his excessive air travel to conferences and crimes against the planet. Aviation emissions have twice the impact on the climate as emissions at ground level, and they are set to increase by 3% each year. And to what end? There are far more effective means of keeping up to date. But as Dr Miles plaintively points out, he is not the only doctor who has used more than his fair share of the atmosphere.

No, we are all doing it. Even the *BMJ*'s editors are off, heading for Chicago this week for a brief immersion in the esoteric world of the science of peer review. It's a chance to meet mentors and colleagues who have over the years become important friends; four days in which to bask in the shared delusion that what we do actually matters.

While we jet off across the Atlantic, we seem to have done nothing to bridge the divide between the sexes. Several, presumably white, males have been hurt by the italic subheading we used on the journal's cover last week: "The days of white male dominated medicine are numbered." Dr Anonymous emailed us to say that he found it "aggressive, insulting, prejudicial and [it] would not be tolerated for any other societal group." He asks how I would have felt as a medical student to have the impending absence of my gender from medicine celebrated on the *BMJ*'s cover. Not great I am sure. Except that the subheading celebrates nothing of the sort. The words, taken from Isobel Allen's article in last week's journal, simply reflect the changing demographics of medicine, and absence of white men was not what she was predicting. But then who could possibly be in favour of continuing domination by any ethnic group or sex? Isn't representative diversity what we are looking for? Getting on that plane may be the answer after all.

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