If you read only one thing this week

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Two years ago the UK government said it would introduce a minimum price on a unit of alcohol. Instead it chose to ban below-cost selling. Alan Brennan and colleagues have now modelled the two approaches and found a big difference in their likely impact (BMJ 2014;349:g5452, doi:10.1136/bmj.g5452). A minimum unit price of 43p (€0.55; $0.69) would affect nearly a quarter of all units sold, compared with just 0.7% affected by the ban. Our editorialist Tim Stockwell (BMJ 2014;349:g5617, doi:10.1136/bmj.g5617) thinks we can trust this analysis and wonders why the UK alcohol industry is so against a minimum unit price, while the policy has been embraced in Canada. Could it be the fear that the policy would prove beneficial to health and open the door to restrictions of other health harming commodities such as tobacco and fast food?

This battle for the public’s health accompanies a host of clinical content in The BMJ this week. Perthes’ disease is easily missed. As Peter Kannu and Andrew Howard explain, just under half of cases are diagnosed at an advanced stage (BMJ 2014;349:g5584, doi:10.1136/bmj.g5584). The problem for doctors is that musculoskeletal complaints are common in children and are usually benign.

Meanwhile, Kristin Jensen and Peter Bulova review the management of adults with Down’s syndrome (BMJ 2014;349:g5596, doi:10.1136/bmj.g5596). Often now living well into middle age, people with the syndrome have several factors in their favour, including a lower risk of hypertension, coronary heart disease, and solid tumours. But their doctors need to be on the lookout for other conditions: hypothyroidism, sleep apnoea, osteoporosis, Alzheimer’s dementia, and respiratory infection, which is the leading cause of death.

Mike Crawford and colleagues ask whether mood stabilisers are helpful in treating borderline personality disorder (BMJ 2014;349:g5378, doi:10.1136/bmj.g5378). UK and US guidelines give conflicting advice, and our authors decide against. While acknowledging the challenges of supporting these patients, they point to a lack of good evidence of benefit, adverse events, and potential toxicity.

What of the controversy over whether doctors should be allowed to prescribe the unlicensed drug bevacizumab (Avastin) for wet age related macular degeneration instead of the much more expensive and licensed ranibizumab (Lucentis)? Already shown to be equally effective, bevacizumab has now been found by a Cochrane review to be safe. In his blog (http://bit.ly/1ByeKpH) David Lock says it’s time for healthcare commissioners to act rationally and show courage. “Why should an NHS under vast financial pressure give clinicians the choice to use a less cost effective drug?” he asks. It should be bevacizumab or nothing.

So there’s no shortage of clinical reading. But if you have time for only one article this week let it be “The science of anthropogenic climate change: what every doctor should know” (BMJ 2014;349:g5178, doi:10.1136/bmj.g5178). As I explain in a linked editorial (BMJ 2014;349:g5945, doi:10.1136/bmj. g5945), this Analysis article is pure climate science, intended to give you information you will need to become informed advocates for action against climate change. Time is short, geophysically and politically. We have just over a year until the next round of climate talks in Paris in December 2015. If you haven’t already done so please visit the Global Climate and Health Alliance website (www.climateandhealthalliance.org) and see what you can do to make your voice heard.

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