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EDITOR'S CHOICE

Human recombinant erythropoietin not only increases the haemoglobin concentration of uraemic patients, it also makes them feel better, a Canadian multicentre study has found (p 573). It goes almost without saying that this was a double blind, randomised, placebo controlled study. Not so a multicentre trial from the United States which came to similar conclusions and was reported in the *Journal of the American Medical Association* last month. Accompanying the paper—slightly odd, this—was an editorial rapping the investigators' knuckles for having failed to perform a randomised study and for having excluded patients if they had a disease "that would interfere with data analysis." Similarly, in this week's journal the authors of an overview of studies of angioplasty for renovascular hypertension criticise the haphazard and unscientific way in which angioplasty has been evaluated (p 569). Despite the absence of any randomised trials comparing transluminal angioplasty with other treatments for renovascular hypertension angioplasty seems to be emerging as the treatment of choice. The authors lament the sharp contrast in the quality of data that is acceptable for evaluating a practical procedure and a new drug, but, as the example of erythropoietin suggests, the gap may not be as wide as the authors think. Thought for the week: should the introduction of (invariably expensive) new drugs and technologies into medical care be better policed? And if so, how, and by whom?