Water quality and diarrhoea, pp 755, 782

REX

Scars that won't heal, p 801

Mothers with HIV don't have to have infected babies, p 763

EDITORIALS

LETTERS

NEWS

FEATURES

HEAD TO HEAD

OBSERVATIONS

YANKEE DOODLING

ANALYSIS

RESEARCH, CLINICAL REVIEW, AND PRACTICE

See next page

VIEWS AND REVIEWS

PERSONAL VIEWS

NETLINES

Harry Brown

REVIEW OF THE WEEK

COLUMNISTS

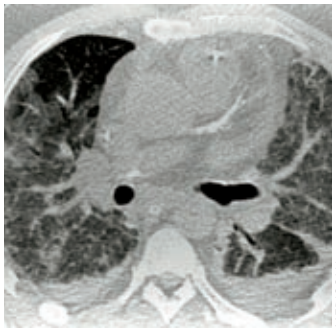
MEDICAL CLASSICS

OBITUARIES

MINERVA

European Working Time Directive, p 770

BMJ


MEDISCAN

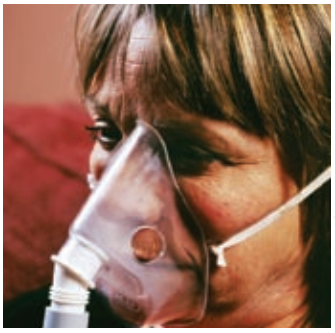
Nitric oxide and acute lung injury, p 779


CDC

Home water quality and diarrhoea, p 782


PHOTOS.COM

Intensive care: a patient's journey, p 796


COLIN CUTHBERT/SPL

COPD in a 10-minute consultation, p 798

RESEARCH

CLINICAL REVIEW

PRACTICE

LATEST RESEARCH ONLINE

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14 April 2007 Vol 334

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PICTURE OF THE WEEK

A child walks out after surgery in the flying eye hospital in Mumbai, India, last week. The world's only flying eye hospital is on a two week mission to India to perform free surgery and train hundreds of eye care personnel in a country that has the world's largest number of blind people.

THE WEEK IN NUMBERS

4 Days of improved oxygenation in patients with acute lung injury who were given nitric oxide **(Research p 779)**

1.8 million Child deaths a year from diarrhoea **(Editorial p 755)**

50% Reduction in sexually transmitted infections if prostitution were legal and regulated in the UK, according to unsubstantiated claims by chairman of the BMA's public health committee **(News p 790)**

48 hours Maximum weekly working time in Europe **(Feature p 770)**

49.10 World Health Assembly resolution to destroy the smallpox virus, in 1999, balked at by Russia and the US **(Head to Head p 774)**

THE WEEK IN QUOTES

"Trialists [should] restrict their use of composite end points to end points of similar importance to patients" Research p 788)

"Interventions were effective in reducing diarrhoea even without improved sanitation" (Research p 782)

"In the light of modern science . . . [Hippocrates and Galen] killed much more often than they cured" (Letter p 762)

"Extravagant and obvious self destructiveness . . . at least lend to the vacuity of their existence the patina of drama" (Between the Lines p 803)

"The risk of mothers passing HIV to their babies can be reduced simply and cheaply" (News p 763)

ON THE COVER

Smallpox: is it time to destroy the virus?

See Head to head, p 774

COVER IMAGE:CDC /SPL

PLUS

Articles appearing in this print journal are likely to have been shortened.
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bmj.com also contains material that is supplementary to articles: this will be indicated in the text (references will be given as w1, w2, etc) of the article and be labelled as *e*xtra on bmj.com.

EDITOR'S CHOICE

Caveat emptor

If you read only one thing in the *BMJ* this week, it should be the article by Ferreira-González and colleagues, with its accompanying editorial (well, that makes two things). Rory Watson's article on whether Europe will achieve a 48 hour week is important (p 770), as is the related article on how to make shift work more bearable and less damaging to health (p 777). Doug Kamerow's "Yankee Doodling" (p 776) is highly deserving of your time, as are the smallpox debate (p 774), the clinical review on post-traumatic stress disorder (p 789) and this week's medical classic—*La Belle Dame Sans Merci* (p 803). But Ferreira-González et al's systematic review (p 786) is like a great big "caveat emptor" sign hanging over the portal of the world's most influential clinical trials.

What they've done is to look at how trials use composite end points—for example, combining rates of death, myocardial infarction, and revascularisation when comparing two treatments. This is standard practice and quite legitimate: composite end points reduce the number of patients needed in any trial and can give a sense of the overall clinical impact of a treatment. But this practice becomes a problem if the component parts of the composite end point differ widely in their importance to patients, and if the less important end points (treatment failure, for example) are much more common than the more important ones, such as death. Ferreira-González and colleagues found this to be the case in most of the cardiovascular trials published in six leading journals. They say that readers could be misled into believing that a new treatment reduces deaths when it doesn't. Clearly, such a conclusion would be gold dust to the marketing of a new drug.

In their editorial, Freemantle and Calvert (p 756) say that the current system of drug regulation tends to encourage both the use of composite end points and the addition of death to those composites. To help people interpret trials correctly, they suggest a health warning that makes it clear which parts of a composite end point were affected by the new treatment and which were not.

Drug regulation, and how it could be improved, was at the heart of discussions in Rome last month at a meeting organised by Italy's pharmaceutical agency, AIFA. Representatives of industry argued that drug licensing and reimbursement decisions were too slow and inconsistent across Europe and worried about the lack of incentives to innovate. Academics argued that "speed to market" must be secondary to proper evaluation of a new drug, including head to head comparisons against current best treatment. Silvio Garattini, chairman of AIFA's research committee, called for more independent, publicly funded evaluations of new drugs. Garattini is behind Italy's revolutionary 5% tax on drug marketing expenditure, which funds independent trials and has set a standard for other countries to follow.

The meeting was an attempt to move beyond confrontation to constructive dialogue with the pharmaceutical industry. In the same spirit, the *BMJ* will be running articles over the next few months exploring drug development, licensing, evaluation, and marketing. We all want safe, effective, innovative drugs. The question is how best to achieve that.

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