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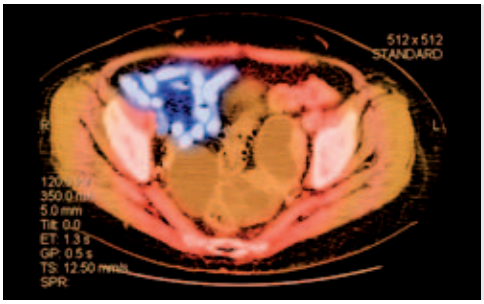

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Articles appearing in this print journal have already been published on bmj.com, and the version in print may have been shortened. bmj.com also contains material that is supplementary to articles: this will be indicated in the text (references are given as w1, w2, etc) and be labelled as extra on bmj.com.

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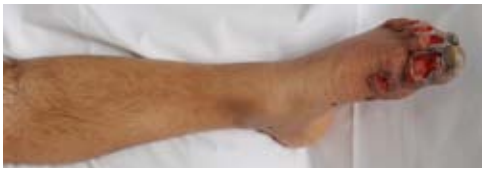

MINERVA

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SOUTHBANK CENTRE

PICTURE OF THE WEEK

As part of *Death: Southbank's Festival for the Living*, Candy Chang's installation *Before I Die* encourages people to finish the sentence "Before I die I want to . . .." The two day festival this weekend at London's Southbank Centre explores attitudes towards death through talks, debate, and performances.

MOST READ ON BMJ.COM

Search for evidence goes on

Cardiovascular researcher fabricated data in studies of red wine

Timing of onset of cognitive decline: results from Whitehall II prospective cohort study

Orthopaedic surgeons: as strong as an ox and almost twice as clever? Multicentre prospective comparative study

Antihypertensive drugs and risk of incident gout among patients with hypertension: population based case-control study

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Does anyone understand the government's plan for the NHS?

Timing of onset of cognitive decline: results from Whitehall II prospective cohort study

Bad medicine: medical nutrition

Proposals to increase the motorway speed limit by 10 mph

Benefits and harms of mammography screening

BMJ.COM POLL

Last week we asked, "Should public funds pay when private healthcare goes wrong?"

82% voted no (total 1055 votes cast)

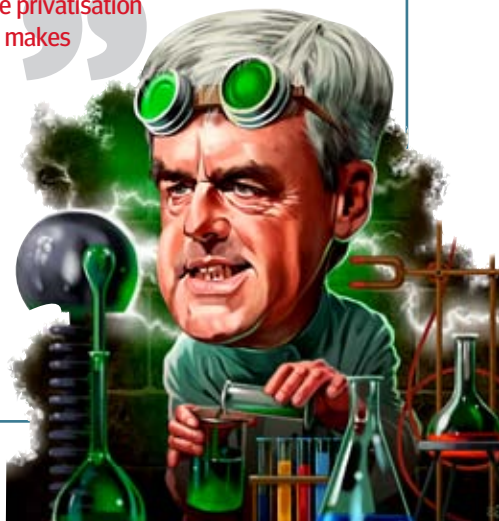
This week's poll asks, "Does anyone understand why we need the government's plans for the NHS?"

bmj.com *BMJ* 2012;344:e399

RESPONSE OF THE WEEK

"If one views the government's plan as an attempt to improve the NHS, it makes no sense at all. However, if viewed from an economic standpoint, and seen as a classic Friedman school move to create a crisis in order to facilitate the privatisation of public services, it makes complete sense."

John Matthews, ambulance paramedic, Weybridge, in response to "Does anyone understand the government's plan for the NHS?" (*BMJ* 2012;344:e399)



EDITOR'S CHOICE

Controversies over hypertension guidelines

The guideline's authors argue that the recommendations are evidence based and that this latest guidance is an evolution that will continue as more evidence accrues

The proper management of hypertension is arguably one of modern medicine's most effective preventive interventions. It's also one for which we have lots of clinical trial data, as well as a good number of well done meta-analyses. Yet as this week's *BMJ* shows, controversy about how best to diagnose and treat hypertension in adults is still alive and well.

The 2011 guidance from the UK's National Institute for Health and Clinical Excellence (NICE) has been met with a blast of criticism. This week we present two different critiques: the first suggesting that the guidelines are overcomplicated, the second that they are insufficiently evidence based. In a third article, the guidelines' authors respond.

The 2011 update made several key changes to previous guidance. These included advice to use ambulatory and home blood pressure monitoring to confirm a raised clinic reading, and a different choice of drug class for first and second line treatment. In place of the well established AB/CD algorithm—ACE inhibitor or β blockers/calcium channel blocker or diuretic—the updated guidance recommends ACD in people under 55: ACE inhibitor or angiotensin II receptor blocker, followed by a calcium channel blocker, followed by a thiazide-like diuretic. Patients over 55 are recommended to start on a calcium channel blocker.

Reecha Sofat and colleagues think this is overcomplicated (p 20). The most recent evidence suggests that the four drug classes are more similar than different in their efficacy and safety, they say, and that their effects in combination are additive. This means that the initial choice of drug could rest on price, tolerability, and individual patients' characteristics.

Morris Brown and colleagues take a different tack (p 23). They say there are no outcome data from trials that justify the shift to ambulatory and home monitoring, and they are surprised by NICE's conclusion that ambulatory monitoring could cut the number of people starting on antihypertensive drugs by a quarter. "The combination of a rise, compared to previous guidance, in the blood pressure threshold for treatment and a longer interval before repeat monitoring is not plausible, evidence based, or safe," they say. They are equally concerned about the relegation of diuretics from first to third line treatment, and the recommendation to use chlortalidone, for which no suitable 12.5 mg formulation is available in the UK. Good cheap drugs such as co-amilozide are overlooked, they say.

In reply, the guideline's authors argue that the recommendations are evidence based and that this latest guidance is an evolution that will continue as more evidence accrues (p 27). Both sets of critics say that, despite the many trials and meta-analyses already done, a great many questions remain. Brown and colleagues try to make the best of what they clearly see as a bad job in calling for the latest NICE guidelines to serve as a catalyst for more robust clinical trials. Sofat and colleagues call for an updated network meta-analysis, taking into account the evidence from recent large influential trials and meta-analyses.

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Features and analysis online at bmj.com

The story behind the Cochrane review

The team updating the Cochrane review of neuraminidase inhibitors in healthy adults found that the public evidence base for this global public health drug was fragmented and inconsistent. Peter Doshi, from Massachusetts Institute of Technology, USA, and colleagues tell the story (doi:10.1136/bmj.d7898).

Tamiflu latest

Why did different regulators take different approaches to the data on oseltamivir (Tamiflu)? Deborah Cohen investigates how Europe, the USA, and the World Health Organization are at odds with their conclusions about what the drug does (doi:10.1136/bmj.e458).