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## Bad medicine: the menopause

I completely concur with Dr Des Spence: Big Pharma is manipulating doctors and exploiting patients, and Big Medicine is neglecting its role to protect patients.<sup>1</sup>

I can remember, shortly after becoming a GP Principal in 1987, a drug representative trying to persuade us to prescribe evening primrose oil capsules for itching in eczema. The glossy presentation and neurolinguistic programming attempts to persuade failed because of my training. A study of  $n = 20$  can prove anything. So how did it get a licence? Of course, after many years its licence was withdrawn as there was no evidence of positive effect.

Later I asked drug representatives two questions: What is the number needed to treat (NNT)? And what is the number needed to harm (NNH)? The response was mostly gobbledeygook, or I'll get back to you, which they never did.

Looking at this more seriously, if referees and journal editors insisted on NNT and NNH figures in research/review papers, instead of relative risk everybody would understand the results more easily. It is depressing that many health media correspondents do not know the difference between actual risk and relative risk, and so misinform the public on the effectiveness of treatments. Unfortunately this is unlikely to happen as even NICE refuses to adopt NNT and NNH as a type of outcome description.

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## Chronic fatigue syndrome: is the biopsychosocial model responsible for patient dissatisfaction and harm?

Geraghty and Esmail have done well to draw attention to the substantial biomedical literature now extant around chronic fatigue syndrome (CFS).<sup>1</sup> They are right to point out that the dominant model has been a biopsychosocial (BPS) one, and that this has led to persistent disagreement between doctors and patients. What is particularly salutary is the absence of any advance in therapy, so that they recommend, for example, cognitive behavioural therapy (CBT), but with the caveat that it might not be helpful in individual cases. CFS continues to challenge GPs by its resilience to treatment, but colleagues will be well advised to take on board the changing evidence for pathophysiology set out in this article. Many of the cited papers are accessible and worth reading, such as the authors' reference 8,<sup>2</sup> and in that paper, reference 38.<sup>3</sup>

The bottom line for me is respect for the patient, and humility in the face of lack of knowledge about the precise causes of CFS, which is clearly anyway a heterogeneous group of conditions.

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## Chronic fatigue syndrome and the biopsychosocial model

I was pleased to see this article highlight the potential harms of graded exercise therapy (GET) and CBT for patients with myalgic encephalopathy (ME).<sup>1</sup> I myself was diagnosed with ME as a 20-year-old student in early 1984 by a consultant neurologist in Glasgow. My illness was triggered by Coxsackie B4 virus — there was an outbreak of Coxsackie in the West of Scotland at this time. Since my own diagnosis with this poorly understood illness, I have been baffled — and shocked — to see the criteria of ME diluted in the early 1990s and the consequent conflation with unexplained 'chronic fatigue'. Moreover, the adoption of the biopsychosocial model of 'ME/CFS' has certainly not been beneficial to my own experience of illness. I am hopeful that, with the dedicated international biomedical researchers we now have, there will be effective therapies in my lifetime. There are many, many people who truly suffer with this dreadful illness.

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## Hypertension in surgical patients: the role of beta-blockers

We read the editorial on 'Preoperative blood pressure measurement: what should GPs be doing?' with great interest.<sup>1</sup> In support of the lack of evidence that reducing blood pressure helps, the authors quote the POISE study,<sup>2</sup> stating that beta-blockers were used to reduce blood pressure preoperatively and the data suggested that it did more harm than good. POISE was not designed to test the effects of reducing blood pressure before

surgery in hypertensive patients, but rather to assess whether introducing beta-blockade immediately prior to surgery and continuing it for 30 days reduced the risk of cardiac events in patients at risk of, or with, coronary artery disease, vascular disease, previous stroke, etc. In POISE, about 60% of patients had a history of hypertension, but there are no data on the quality of blood pressure control or the presence or absence of elevated blood pressure at the time of surgery. Hypertension did not figure among the predictors of adverse outcome, and no data suggest that beta-blockade did more harm than good specifically in hypertensive patients.

We are concerned that your editorial may lead some readers to conclude erroneously that patients on beta-blockers may be particularly at risk and that beta-blockers should be stopped. Beta-blockers are no longer first-line treatment for hypertension, yet, in those receiving them for indications such as coronary artery disease or tachyarrhythmias, cessation prior to surgery could be harmful. Indeed, maintaining beta-blocker treatment receives a Class I recommendation in the recent ACC/AHA/ASA and ESC/ESA guidelines.<sup>3,4</sup>

We think this needs to be clarified as misinterpretation of your editorial may result in the unnecessary and potentially harmful discontinuation of beta-blocker therapy.

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## Encouraging medical students to pursue general practice

There are, I am sure, a number of GPs who are still enthusiastic about the job (including those, like me, who are part-time GPs as part of a 'portfolio career') who do not have the time or opportunity to act as GP tutors to medical students or F2 doctors but who would value the opportunity to share our enthusiasm.<sup>1</sup> Perhaps access to registrar half-day training sessions or undergraduate events would provide a forum for this? Or even an evening event?

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## Incidence of cow's milk protein allergy

This was a really useful article and will clear up a lot of the confusion between these conditions.<sup>1</sup> However, I think it is also useful to note that, although the incidence of cow's milk protein allergy (CMPA) in formula-fed babies is around 5–7%, in breastfed babies it is 0.5–1%. That's not to say this is a stick we can use to beat bottlefeeding mothers with, but when a breastfed baby presents with symptoms that may be due to CMPA, we should be slower to assume that this is the

case, and certainly should not rush to advise mothers to restrict their diets excessively.

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## Barriers to advance care planning in primary care

One of the main themes to emerge from Mitchell and colleagues' qualitative data analysis is the importance of advance care planning (ACP) in identifying early palliative care needs and recognising the end of life.<sup>1</sup> Other benefits of ACP include less aggressive medical care, improved quality of life near death, assisting families to prepare for a loved one's death, resolving family conflict, and coping with bereavement.<sup>2</sup> Patients however may not wish to engage in discussions about future care as it involves them thinking about a deterioration in their condition and some GPs may be unwilling to initiate ACP discussions as they feel discussing prognosis with patients will cause undue distress and destroy hope.<sup>3</sup>

ACP has the potential to promote patient autonomy and shared decision making,<sup>4</sup> but without a significant change in patients' perception and GP attitudes it is unlikely to be more widely adopted.

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