

STATINS

Best interests of patients, not influence from pharmaceutical industry

From Dr S. Jarvis, FRCGP

Our article on statin use distributed with *The Journal* of 20 January makes it abundantly clear that simvastatin should be the first line treatment for all patients. What seems to have aroused the wrath of so many of your readers (*PJ*, 3 February, pp129–31) is the suggestion that any guidance other than National Institute for Health and Clinical Excellence guidance should be used by health care practitioners. It is implied that my failure to include reference to either the draft NICE guidance on secondary prevention of myocardial infarction¹ or the circular from Roger Boyle to NHS clinicians² is a deliberate attempt to mislead readers.

The explanation is much simpler. I wrote my part of this document before the publication of either the draft NICE guidance on secondary prevention of MI, or the circular from Roger Boyle. Had I written it after their publication, I would, of course, have included both. I would also have included details of the cost-effectiveness analysis of the “Heart protection study”, published more recently still,³ which demonstrated that statin use is cost-effective for a much wider range of patients than those for whom it is recommended in the UK, even if non-generic statins are used.

I would have reminded readers that both Dr Boyle’s letter and the NICE guidance on secondary

prevention of MI recommend that doctors in England and Wales should use guidance which fails to take into account any evidence less than six years old, including the landmark “Heart protection study” (which used simvastatin).⁴

The NICE guidance on statins, published in 2006,⁵ recommends that statins should be used for a much wider section of the population than that recommended by the National Service Framework for Coronary Heart Disease of 2001.⁶ Thus, the NICE guidance on statins accepts that enough new research on the effectiveness of statins has emerged since 2001 for the NSF on CHD to be out of date — yet the draft NICE guidance on secondary prevention of MI recommends that we continue to work to these outdated guidelines in some of our highest risk patients.

The replies to the article suggest that the JBS-2 guidance⁷ is not evidence-based. Interestingly, its recommendations were drafted before the publication of the Cholesterol Trialists’ Collaboration meta-analysis of 164 clinical trials,⁸ which, by showing a clear and predictable negative correlation between reductions in low density lipoprotein cholesterol and mortality, provides ample evidence of the continued benefits of lower cholesterol targets.

In introducing the concept of NICE,⁹ its chairman Sir Michael Rawlins outlined the need for a national body to counter, among other problems, the “too frequent failure to provide patients with optimum care for the treatment of common diseases”, and the fact that “health care professionals in the UK are sometimes too slow to introduce effective new treatments”. Yet the circular from

Dr Boyle and the draft NICE guidance on secondary prevention of MI, in asking us to continue to use guidance which is six years out of date, are effectively instructing us to perpetuate, rather than to resolve, these potentially serious deficiencies in care.

When NICE was introduced it was stipulated that its guidance would be just that — guidance. This guidance would not be mandatory, and clinicians would continue to have the freedom to exercise their clinical judgement based on the best interests of their patients.

I take seriously my duty to use the resources of the NHS efficiently. I also take seriously my duty to provide my patients with the highest quality of care. The article was part of my ongoing attempt to reconcile these two duties. Your readers, however, imply that my failure to work to national guidelines which I consider, for the reasons above, to be contrary to the best interests of patients must be motivated by undue influence from the pharmaceutical industry. I find such accusations offensive in the extreme.

Sarah Jarvis

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References

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3. Heart Protection Study Collaborative. Lifetime cost effectiveness of simvastatin in a range of risk groups and age groups derived from a randomised trial of 20 536 people. *BMJ* 2006;333:1145.
4. Heart Protection Study Collaborative Group. MRC/BHF heart protection study of cholesterol lowering with simvastatin in 20,536 high-risk individuals: a randomised placebo-controlled trial. *Lancet* 2002;360:7–22.
5. National Institute for Health and Clinical Excellence. Statins for the prevention of cardiovascular events. NICE technology Appraisal 94. London: NICE; 2006.
6. Department of Health. National Service framework for Coronary heart Disease. London: The Department; 2001.
7. JBS 2: Joint British Societies’ guidelines on prevention of cardiovascular disease in clinical practice. *Heart* 2005; 91:1–52.
8. Cholesterol Treatment Trialists’ (CTT) Collaborators. Efficacy and safety of cholesterol-lowering treatment: prospective meta-analysis of data from 90,056 participants in 14 randomised trials of statins. *Lancet* 2005;366:1267–78.
9. Rawlins M. In pursuit of quality: the National Institute for Clinical Excellence. *Lancet* 1999;353:1079–82.

Making the most of NHS resources

From Mr N. J. Wicks, MRPharmS

In response to the correspondence in last week’s *Journal* (3 February, pp129–31), I would like to add my comments to those of Sarah Jarvis (above). First, throughout our document we advocated simvastatin as the first-line initiation therapy. This was based on a low acquisition cost. Secondly we acknowledged that there were different sets of guidance that could influence the lipid levels to which prescribers may wish to treat. Indeed I need look no further than my own health board to see one part of the NHS which has decided to set the lower target of 4mmol/L for total cholesterol.¹

Following on from this we went on to discuss the budget impact, using simvastatin first line, of treating to reach either the 5mmol/L or 4mmol/L total cholesterol levels. This discussion was aimed at making the most of NHS resources should patients fail to reach either target using simvastatin. I do not believe the comments of your correspondents reflected these points but sought to stifle debate by suggesting that we had tried to pass the document off as something it clearly was not.

The issuing of guidelines by anyone, be they the NHS or professional bodies, are exactly that — guidelines. Indeed we can expect to see the latest set of guidelines from the Scottish Intercollegiate Guidelines Network issued this week. No doubt these will further serve to inform decisions on how best to deploy NHS resources.

Noel Wicks

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Reference

1. Forth Valley Formulary, November 2006. Available at: www.communitypharmacy.scot.nhs.uk (accessed 6 February)

Letters to the editor

Letters for publication can be posted, faxed, or sent by e-mail to letters@pharmj.org.uk and should not normally be of more than 400 words and should cover one topic only. *The Journal* reserves the right to abridge letters and to edit them for clarity and style. Pharmacist correspondents should supply their membership numbers and a contact telephone number should always be given. Women correspondents should specify a preferred title otherwise “Ms” will be used.

Letters are accepted for publication on the understanding that they have not appeared anywhere, including electronic media, previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform *The Journal* at the time.

Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors’ identities will not be disclosed until publication, and publication will usually be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

Events

The Journal welcomes details of future events relevant to pharmacists. There is no charge for insertion of an item but *The Journal* is unable to guarantee insertion on any given date.

Details can be sent by e-mail to notice-board@pharmj.org.uk

■ ADVERTISING

ABPI code extends beyond legal requirements

From Ms H. Simmonds

The Pharmaceutical Journal (3 February, pp129–31), published five letters (criticising, inter alia, the content of, and AstraZeneca's role in, an insert discussing statins sent with the *PJ* of 20 January.

As is our usual practice the criticisms have been taken up as complaints under the Association of the British Pharmaceutical Industry (ABPI) code of practice for the pharmaceutical industry. If prima facie cases are established, details will appear on our website (www.pmcpa.org.uk).

It is disappointing that the *PJ* did not mention the ABPI code in the editorial comments — particularly as it is drawn up in consultation with the Royal Pharmaceutical Society and reports on cases regularly appear in the *PJ*. In addition details of certain cases are advertised in the *PJ*. The leading article (*ibid*, p120) mentioned “industrial or regulatory codes of practice” in the

context of the document not breaking such codes as far as the *PJ* was aware. In line with its procedures the Prescription Medicines Code of Practice Authority (PMCPA) will first determine whether AstraZeneca's document comes within the scope of the code and then whether or not there has been a breach.

The editor mentioned the Medicines and Healthcare products Regulatory Agency complaints procedure (p131). The MHRA, ABPI and PMCPA have drawn up a memorandum of understanding which sets out the roles of the parties in the regulation of the promotion of medicines for prescribing and it is available on the PMCPA and MHRA websites. The MHRA supports self regulation and sees efficient, stringent and transparent self regulation as a means of ensuring that the regulatory requirements are met by self regulation with intervention by the MHRA when there is a clear case for protection. The ABPI code reflects and extends beyond UK legal requirements.

Pharmacists who are concerned about pharmaceutical company materials or activities should

contact the PMCPA (tel 020 7747 8880, e-mail complaints@pmcpa.org.uk).

Heather Simmonds

Director

Prescription Medicines Code of Practice Authority

■ PHYSICIAN ASSISTED SUICIDE

Sometimes in the patient's best interest

From Mrs A. B. V. Chalmers, MRPharmS

I find the plea made by Mark Donaghy (*PJ*, 3 February, p133) for the Royal Pharmaceutical Society to state that pharmacists object to the use of pharmaceuticals for intentionally killing patients far too sweeping and high-handed when one considers the context in which he makes it.

Perhaps Mr Donaghy has never seen extreme suffering in a human being, suffering which renders life to the holder more objectionable than the prospect of oblivion through death. If physicians are to assist in putting such patients out of their misery by either providing

the drugs or, where the patient is so incapacitated as not to be able to manage administration for themselves, actually administering the drugs, then who are we to withhold the provision?

Of course, there should be a conscience clause, not only for pharmacists but also for physicians not wanting personal involvement in such a procedure.

I see the role of medical and paramedical professionals as being one of a duty of care and to act in the best interests of a patient. Sometimes, physician-assisted suicide or voluntary euthanasia is that best interest. The “conscientious” pharmacist should tell the prescribing physician which is the nearest pharmacy at which to obtain the necessary pharmaceuticals.

Anthonia Chalmers

London

Broad spectrum

Contributions of around 1,100 words commenting on topical issues should be sent to graeme.smith@pharmj.org.uk for consideration

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