SHORT CUTS

ALL YOU NEED TO READ IN THE OTHER GENERAL JOURNALS

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A tax on sugary drinks would improve public health, say US experts

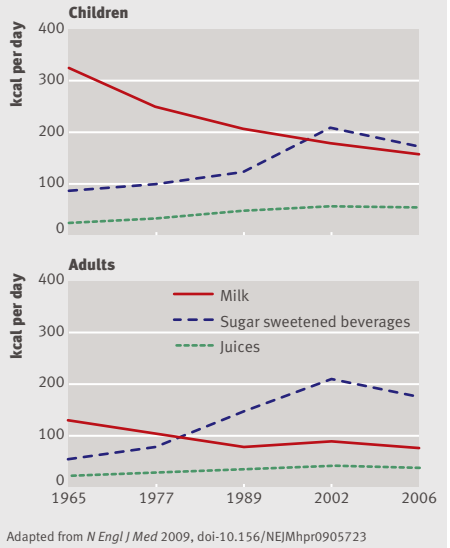
A panel of public health experts from across the US have urged federal and state governments to tax sugary drinks in an attempt to control the obesity epidemic. They propose taxing producers and wholesalers 1 cent per fluid ounce on all drinks containing added sugars.

The evidence linking sweetened drinks to obesity and poor health is already compelling, they write. So is the evidence that taxing unhealthy products reduces consumption. Public support for some kind of tax is growing, particularly if tax revenues are earmarked for public health programmes to tackle obesity and encourage healthy lifestyles.

The panel estimates that a 1 cent per ounce tax would reduce calorie consumption from sugary drinks by around 10%. This drop would be enough to produce measurable health benefits in a population that has doubled its intake of sugary drinks over the past few decades. A national tax would generate nearly $15bn (£9.2bn; €10bn) in the first year.

The health problems caused by overweight and obesity currently cost $147bn, nearly 10% of all US healthcare expenditures. Governments have a right to recoup some of these costs from the drinks industry and should be prepared for strong opposition, including the kind of tactics previously employed by tobacco companies in response to taxes on cigarettes.

TRENDS IN CALORIES FROM DRINKS



Adapted from *N Engl J Med* 2009, doi:10.1056/NEJMhpr0905723

The drinks industry has already established an organisation called "Americans Against Food Taxes," and other similar initiatives are likely to follow.

N Engl J Med 2009, doi:10.156/NEJMhpr0905723

Administrative staff help treat depression in small practices

Case management is an effective strategy for treating depressed patients in a primary care setting. It's also beyond the means of many small general practices. So researchers evaluated telephone support given by trained healthcare assistants already employed by small practices in Germany.

In a cluster randomised trial, patients who were telephoned regularly by trained assistants had slightly but significantly lower symptom scores after 12 months than patients who had usual care (10.7 *v* 12.1 out of a maximum score of 27; P=0.014). They were more likely than controls to have improved by at least 50% from baseline (100/242 (41.2%) *v* 74/272 (27.3%); P=0.003).

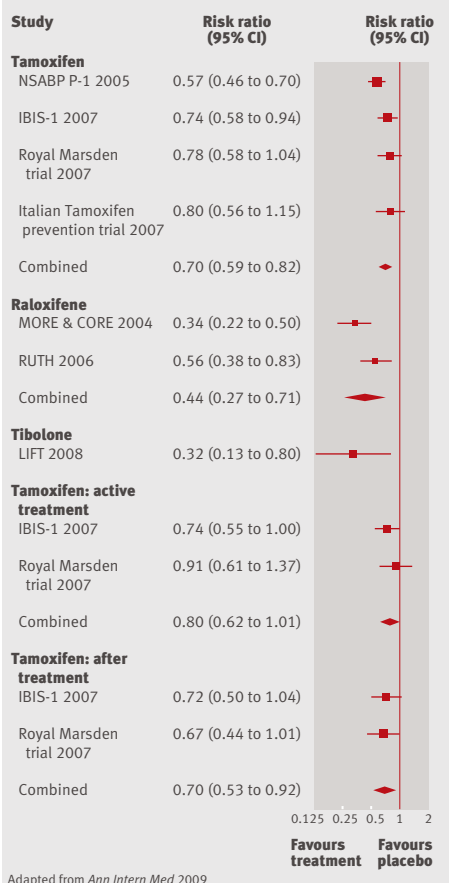
Healthcare assistants in Germany do administrative work and simple clinical tasks, say the authors. They have three years of on the job training after senior school, less than nurses or physicians' assistants. In this trial, healthcare assistants were trained for an extra 17 hours to telephone patients with depression once a month and check their symptoms, ask about adherence to medication, and encourage social activities. Each patient had an average of 14 calls during the year. It seemed to work, and the German government has responded with reforms to ensure funding for clinical work carried out by healthcare assistants.

Ann Intern Med 2009;151:369-78

The ups and downs of primary prevention for breast cancer

Women with a high risk of breast cancer need a safe and effective drug for primary prevention, and oestrogen modulators tamoxifen, raloxifene, and tibolone are under evaluation. In a meta-analysis of eight randomised trials, these drugs reduced the incidence of breast cancer by between 30% and 66% compared with placebo—an effect equivalent to seven to

INCIDENCE OF INVASIVE BREAST CANCER



Adapted from *Ann Intern Med* 2009
www.annals.org/cgi/content/full/0000605-200911170-00147v1

10 fewer cancers per year among every 1000 women treated for five years. Direct comparisons between drugs are difficult though. The review included only one head to head trial, and the results from separate placebo controlled trials weren't comparable because of fundamental differences in the populations under study.

None of the drugs reduced overall mortality from breast cancer or anything else, and all three were associated with serious side effects. Tamoxifen and raloxifene were associated with thromboembolism (between four and seven extra events per year for every 1000 women treated), tibolone caused strokes in older women, and tamoxifen doubled women's risk of endometrial cancer (risk ratio compared with placebo 2.13, 95% CI 1.36 to 3.32). Less serious but still bothersome side effects included hot flushes (tamoxifen), vasomotor symptoms and leg cramps (raloxifene), and vaginal bleeding (tibolone).

The trials in the review were reasonably good quality and included only women without pre-existing breast cancer. The evidence for primary prevention with drugs remains patchy, however, particularly for premenopausal women, those with pre-existing illnesses, and women from a minority cultural background, say the authors.

Ann Int Med 2009, http://www.annals.org/cgi/content/full/0000605-200911170-00147v1

Survival has improved after conservative treatment for early prostate cancer

Older men with localised prostate cancer who opt for conservative treatment are unlikely to die of their disease, according to a cohort study from the US. Among 14 516 men treated conservatively, prostate specific mortality over 10 years was 8.3% for those with well differentiated tumours (95% CI 4.2% to 12.8%), 9.1% for those with moderately differentiated tumours (8.3% to 10.1%), and 25.6% for those with poorly differentiated tumours (23.7% to 28.3%). The men had a median age of 78 years, and were diagnosed between 1992 and 2002. Nearly one third were diagnosed after a screening test for prostate specific antigen, and three quarters of the cohort had moderately differentiated tumours. None of the men had potentially curative treatments such as surgery or radiation within six months of diagnosis, but 42% had androgen deprivation therapy.

These survival figures are substantially better than estimates reported before widespread prostate specific antigen testing, say the authors. Men with early prostate cancer are now much more likely to die of something else, even without invasive treatment. In this cohort, an estimated 56% to 60% of the men died of something other than prostate cancer during the 10 years after diagnosis. Older men with localised cancers that are at least moderately well differentiated should consider surveillance or watchful waiting as an alternative to more invasive treatment, say the authors.

JAMA 2009;302:1202-9

The benefits of ECMO seem modest for adults

Extra corporeal membrane oxygenation (ECMO) can reduce the risk of death or disability in adults with severe respiratory failure, according to a long awaited randomised trial from the UK.

Fifty seven of the 90 patients referred for ECMO survived without serious disability for six months (63%), compared with 41 of the 87 treated with conventional intensive care (47%; relative risk 0.69, 95% CI 0.05 to 0.97). Participants were young and middle aged adults with severe acute respiratory failure. Pneumonia was the most common underlying diagnosis.

The trial was logistically difficult. Patients had to be transferred to a single dedicated centre for consideration for ECMO (68/90 received it), and two of them died in transit. One death was caused by a mechanical failure of the oxygen supply in the ambulance. Other problems included participating intensive care units that couldn't agree on a standardised protocol for controls, and the ethical difficulties of obtaining consent from unconscious, critically ill subjects. Relatives gave "informed assent" on their behalf.

The positive results will be welcomed by ECMO enthusiasts, says an editorial, but are unlikely to convince doubters (doi:10.1016/S0140-6736(09)61630-5). In the end, the benefits looked modest, and didn't stretch to a significant effect on mortality alone. ECMO remains a specialised, technically demanding, and expensive treatment. This trial may not be enough to persuade critical care units to set up an ECMO programme that doubles their costs.

Lancet 2009, doi:10.1016/S0140-6736(09)61069-2

One in 12 survivors of acute renal injury develop end stage renal failure

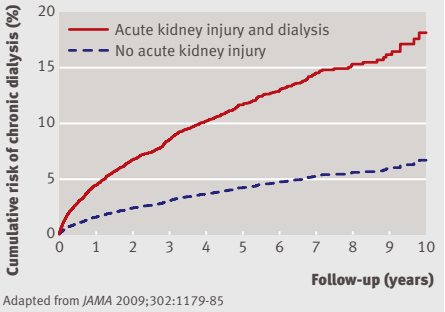
In the ten years to December 2006, 15 028 citizens of Ontario, Canada, needed dialysis for acute renal injury during a hospital admission. Only 8855 made it home alive, says an analysis of the province's healthcare databases. Only 4066 remained alive for at least a month without further dialysis or readmission to hospital.

These selected survivors recovered from their initial renal injury, but around one in 12 still developed end stage renal failure requiring chronic dialysis over the next three years (322/3769 (8.5%)). Their risk of eventually needing chronic dialysis was three times higher than matched controls who had no acute renal injury during a similar hospital admission (adjusted hazard ratio 3.23, 95% CI 2.70 to 3.86). Two commentators estimate that the incidence of end stage renal failure due to an earlier acute kidney injury is at least 0.3 per 100 000 population, or around one third of the incidence owing to polycystic kidneys (pp 1227-9).

In the Canadian study, an acute kidney injury didn't seem to reduce overall survival (0.95, 0.89 to 1.02), but this may be an artefact of the analysis, write the commentators. The authors weren't able to match their cohort to controls with precisely the same baseline renal function, and systematic biases could have crept in that disguised a real difference in survival between the two groups.

JAMA 2009;302:1179-85

NEED FOR CHRONIC DIALYSIS AFTER ACUTE RENAL INJURY



Adapted from *JAMA* 2009;302:1179-85

Patients with pneumonia do better when doctors follow guidelines

Most patients with community acquired pneumonia need empirical antibiotics. US national guidelines recommend a regimen that covers both typical and atypical pathogens—broadly, a combination of a β lactam and a microlide or monotherapy with a respiratory fluoroquinolone. This controversial approach has never been tested in randomised trials, although observational evidence suggests that patients do better when their doctors stick to the guidelines. The two latest observational studies also report significantly lower mortality and shorter hospital stays for patients treated this way.

One study included 54 619 patients with community acquired pneumonia treated in 113 hospitals in Texas. The other analysed data from 1725 older adults hospitalised in 12 different countries. Both compared outcomes between those who did and did not receive recommended empirical regimens. The studies' authors tried hard to adjust for all the potential differences between these two groups of patients. They concluded that residual confounding is unlikely, that the guidelines are probably right, and that doctors should follow them.

These data aren't perfect but they are good, says an editorial (pp 1462-4). A mortality benefit looks likely for patents given the "right" antibiotics, and no observational study to date has reported serious adverse effects. The controversy will not be put to rest, however, until we have the results of at least one large multicentre randomised trial.

Arch Intern Med 2009;169:1515-24, 1525-31

Cite this as: *BMJ* 2009;339:b3877