Letters

Screening without evidence of efficacy

Thyroid ultrasonography is another example

EDITOR—I agree with Law's view of screening, that screening of unproved value should not be advocated.[1] As a clinical endocrinologist I often have to deal with patients' anxieties about non-palpable incidental findings on thyroid ultrasonography, often performed for wrong or unjustified reasons. Sometimes patients arrive with already established surgical complications after unnecessary thyroid operations.

Although a substantial number of incidental thyroid nodules may be histologically malignant,[2] their clinical importance has never been proved. A recent preliminary study indicates that the progression rate of non-palpable proved thyroid malignant nodules to clinically significant lesions may be very low.[3] Thyroid ultrasonography is an additional example of an often used, often non-efficacious screening modality that may lead to "cascade iatrogenesis."[4]

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Competing interests: None declared.

1 Law M. Screening without evidence of efficacy. *BMJ* 2004;328:301-2. (7 February.)
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Screening uncertainties concern evidence, efficacy, decisions

EDITOR—Law argues that encouraging people to decide for themselves whether to attend for screening is ducking the issue.[1] This is true only if a well founded public health programme for a specific disease has not been set up. Then, setting up a programme, as Law advocates, should be based on evidence, through rigorous scientific evaluation of efficacy through systematic review of high quality trials. Outcomes assessed should be both mortality and all associated adverse effects that affect an individual person's quality of life. Good quality evidence based information should also be made available to suit all citizens so that they have a better chance of arriving at an informed decision with their (equally well informed) health professional, if desired.

Provision of such evidence takes time. But the screening industry and the public are not prepared to wait: mammographic screening for those aged 40-50 is widely practised, yet the findings from the AGE trial of breast screening by mammography in young women that began in 1991 and closed in November 2000 are not yet published. Is there not an ethical obligation to make these findings public without further delay?

Encouraging people to decide for themselves through provision of better information is, however, crucial in well established screening programmes such as the NHS breast screening programme for 50-65 year olds.[2] More than a decade of persuasive information has reinforced the intuitive appeal of screening early to save your life in a social and cultural climate that has blossomed on frequently reiterated beliefs.[3 4] Evidence comes a poor second in decision making in a population not educated to see the need for fair tests of treatments, interventions, systems, and processes to underpin what and what is not offered in healthcare systems.[5]

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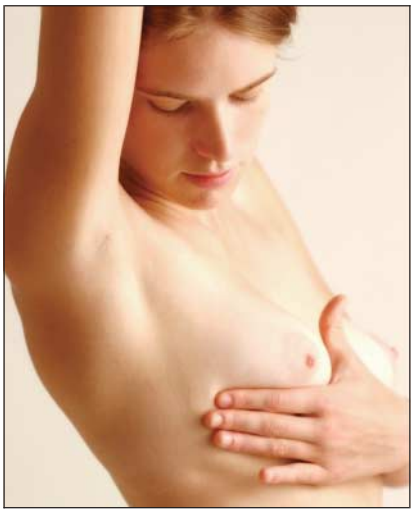
1 Law M. Screening without evidence of efficacy. *BMJ* 2004;328:301-2. (7 February.)



GAROPHANIE/REX

Breast self examination—an example of failure to apply scientific rigour to screening

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Summary of responses

EDITOR—Law's editorial on screening without evidence of efficacy prompted a predictably substantial number of responses that were, perhaps not so predictably, mostly united in their agreement with his objections to advocating screening of unproved value.[1] He concludes: "For a new drug a rigorous set of experimental data must be presented before it is licensed for use, and until it is licensed patients cannot obtain it. The same rigour should apply to medical screening."

Most of the responses questioned the value of screening and threw its potential cost to the public purse into the equation; some highlighted that it was harmful. One correspondent explained what happens if health authorities advocate screening of unproved value, as illustrated by primary prevention of cardiovascular disease in the United Kingdom, where political and financial imperatives to screen and treat have been powerful inducements to change routine practice.

Two correspondents argued passionately that screening (in the form of breast awareness and testing for prostate specific antigen) was a very good thing indeed. Another took a level view and cited systematic reviews to support his own opinion, that the benefits of screening cannot be determined.

Others questioned the drug trial analogy. Randomised controlled trials are appropriate for testing the safety and efficacy of drugs, but they are not appropriate for screening. Drug discovery and development processes are subject to intellectual property laws and governmental regulation. If a pharmaceutical company shows that a new drug is safe and efficacious in a particular condition its investment on research and development costs may well be returned with patent protection and exclusivity rights for several years. No patents exist for screening programmes, and the funding for a thorough evaluation of their risk and benefits would therefore have to come from the public purse.

Another correspondent cites a case in US law as an example of a worst case scenario and asks for rigorous experimental data to be presented before a test is licensed, with people always being informed about the reasons why a test is not available. This would balance claims made by manufacturers' advertisements, which are often based on preliminary studies.

The complexity of the issue is illustrated particularly clearly in a numerical example that an informed decision about testing for prostate specific antigen might be based on. The author reminds us that it is perfectly reasonable to weigh up the pros and cons of screening and conclude that it is a good thing but that advocating a screening programme to others implies an unequivocal benefit.

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BMJ

Competing interests: None declared.

1 Electronic responses. Screening without evidence of efficacy. bmj.com 2004. http://bmj.bmjjournals.com/cgi/content/full/328/7435/301#responses (accessed 19 Feb 2004).

New European clinical trials directive

Is European research possible?

Editor—The concerns expressed by the signatories of the petition to save European research are well founded, and the threats foreseen are in the main real for academic research as well as for smaller biotech and pharmaceutical companies.[1 2] At stake in the EU directive on implementing good clinical practice is the possibility of realising a European dimension to clinical research that has the support of public confidence in the research community.

The role and responsibilities of the sponsor in clinical research are key issues. The directive failed to tackle the complexity of this issue in clinical trials. For the sake of patients, the issue of sponsors' responsibilities needs to be settled throughout European research, with or without the support of the directive.

The future health of Europe's citizens depends on the contributions of government and non-government funded research locally, nationally, and in Europe. Europe cannot afford to lose the power and creativity of its academic researchers or the possibilities offered by the smaller research enterprises. The importance of academic research for European health was not well articulated in the debate that resulted in the directive, with the exception of the steadfast engagement of the European Organization for Research and Treatment of Cancer.

European researchers need to decide what they want to save. Do they wish to pool their knowledge and resources in Europe? Or do they prefer that research (as matters now largely stand) be organised and supported primarily nationally? The upshot of the directive may be that national research is strengthened.

The answers to the challenges do not lie in the directive alone. Directive or no directive, the question is how to create a robust European research environment that ensures patient protection and public confidence in all areas of health research.

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Competing interests: None declared.

1 Watson R. Scientists beg EU to repeal new rules for clinical trials. *BMJ* 2004;328:187. (24 January.)
2 Moulton B. Save European research campaign. *BMJ* 2004;328:286. (31 January.)

Implementation requires funding for effective training programmes

Editor—The European Union's clinical trials directive has been the focus of much attention in the clinical trials community, but it has had little attention, and certainly much less than it deserves, from the wider medical community.[1] Woods's editorial clearly defines the current state of play with this new legislation and its potential impact on non-commercial or publicly funded research.[2]

Woods says that more research staff with better professional training and support may be needed in some publicly funded research. This is in fact an absolute necessity.

The draft statutory instrument that will transpose the EU directive into UK legislation lists more than 30 separate offences, with penalties ranging from a substantial fine to imprisonment.[3] Since ignorance is no defence in law, from 1 May investigators will have to be aware of these new regulations.

Moreover, if NHS trusts and universities are to become sponsors, as laid out in the EU directive, they too must be aware of the wide portfolio of responsibilities that will accompany this role. What better way to achieve this than by providing timely and effective training programmes?

The scale of this task cannot be underestimated. Funding to develop training initiatives has not been readily forthcoming, and we, like other groups who have a leading role in this area, need support to facilitate the implementation process. As part of the better coordination called for by Woods between the major stakeholders (investigators, funders, universities, and NHS organisations), we recommend that funding for the development of training initiatives be put high on the agenda.

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Competing interests: AG and MMBM's clinical trials unit provides and develops training courses in good clinical practice and the conduct of clinical trials.

1 Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use. *Official J Eur Communities* 2001;L121:34-44.
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Reconfiguration of surgical, emergency, and trauma services

Bigger is not better

Editor—Black's editorial on the reconfiguration of surgical, emergency, and trauma services in the United Kingdom discusses what is proving to be a destructive tendency in Scottish medicine and, I suspect, in UK medicine.[1]

A depressing trend prevails in Scotland to see centralisation (sometimes euphemistically described as creating "managed clinical networks") as a reasonable solution to all the ills that currently afflict us. These include the new deal, the consultants' contract, the general practitioners' contract, the European Working Time Directive—all man-made artefacts and all preoccupied with the welfare of doctors, not patients.

A view dominates that unless something can be done to the standard of the Mayo Clinic it should not be done at all. This endangers our small and not so small district hospitals and our specialist services in the regions of Scotland and ultimately leads to the absurd conclusion that we have only one or two hospitals.

We should instead be looking at how we can improve medical services where our people live. We have to do this to encourage the survival and the development of our regional and rural cultures. Fewer and bigger hospitals are certainly not the answer. Other European countries recognise that, and I expect that our electorate will as well. If they don't some of us will be sure to tell them.

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1 Black A. Reconfiguration of surgical, emergency, and trauma services in the United Kingdom. *BMJ* 2004;328:178-9. (24 January.)

Patient power may be the way forward

Editor—The editorial by Black on the reconfiguration of surgical and emergency services in the United Kingdom exudes common sense.[1] Lomond in Scotland has lost accident and emergency surgical services in the past four months, and local general practitioners have had difficulty in securing safe services for the population. This comes on top of loss of maternity services last year at the local district general hospital.

We have been badly served by surgeons who, with their royal colleges, insist on retreating to so called centres of excellence,

with little thought of the price paid by the population deprived of hospital services. Administrators have no choice when surgeons cannot or do not have the will to think "outside the box" for rural or small town communities, but they could support general practitioners trying to provide safe cover for their patients.

Such support is not always forthcoming, and general practitioners are left struggling to provide a service with colleagues in the ambulance service, themselves not adequately consulted on proposed changes and their effect on the locality. Important groups such as the police are not even consulted on proposed changes to local emergency services.

Patients are waking up to the reality of loss of services and are voting out politicians, with examples in England, Scotland, and Northern Ireland. In the west of Scotland general practitioners are working with patients' groups, hospital consultants, and ambulance staff to discuss how local services can be delivered. Patient power has delayed the closure of emergency and surgical services in Fort William, which may be the way forward for coordinated action by concerned communities.

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1 Black A. Reconfiguration of surgical, emergency, and trauma services in the United Kingdom. *BMJ* 2004;328:178-9. (24 January.)

Recommendations are useful for configuring emergency services in the developing world

Editor—The editorial by Black on reconfiguration of emergency services in the United Kingdom is also important for the developing world.[1] Emergency services and acute care constitute a major gap in the focus of the health sector in the developing world, and several issues need to be considered to promote a global dialogue on how best to configure (rather than reconfigure) such services.

Traditional investments in the health sector in the developing world have been biased towards urban areas, large tertiary facilities, and specialty services to the detriment of primary and acute care. This bias needs to be addressed by ministries of health and finance.

The use of non-doctor personnel is critical for the developing world. Shortages of skilled staff, lack of training, and poorly defined career structures plague human resources in the health sector. It is time to assess the potential contributions of other health professionals for emergency care, analogous to the community health workers of primary health care.

Building infrastructure is important for hospitals, clinics, and district facilities. Defining essential equipment and functions seems like an appropriate task for agencies such as the World Health Organization.

Capacity development for responding to emergency is crucial. Training individual doctors is not enough; emergency care systems will need to be built to make a quantum change in responding to the needs of people.

It is time to recognise the great need for acute care in the developing world and call for more investment and efforts in building appropriate systems. Maternal mortality, cardiac deaths, and trauma should all be manageable in the developing word, as in the United Kingdom, by an appropriate emergency medical system.

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1 Black A. Reconfiguration of surgical, emergency, and trauma services in the United Kingdom. *BMJ* 2004; 328:178-9. (24 January.)

Data on neuraminidase inhibitors were made available

Editor—In response to Symmonds et al,[1] F Hoffmann-La Roche would like to clarify that data from studies WV15759/WV15871 were made available to the National Institute for Clinical Excellence.

These were double blind, placebo controlled trials, conducted in children aged 6 or older and 12 or younger, to investigate the efficacy and tolerability of oseltamivir in the treatment of influenza among asthmatic children. Of the 355 children randomised to treatment, 170 received oseltamivir 2 mg/kg and 164 received placebo. Of these children, 179 had laboratory confirmed influenza infection, which represented only 70% of the planned recruitment target. This precluded any statistical demonstration of the primary efficacy end point "time to freedom from illness" (incorporating resolution of symptoms and a return to normal activity).

Among the outcomes of this study, a positive effect on forced expiratory volume in one second in the oseltamivir group was seen, an observation that is being further investigated in an ongoing clinical trial in asthmatic children. We would also like to clarify that we plan to publish the results from studies WV15759/WV15871.

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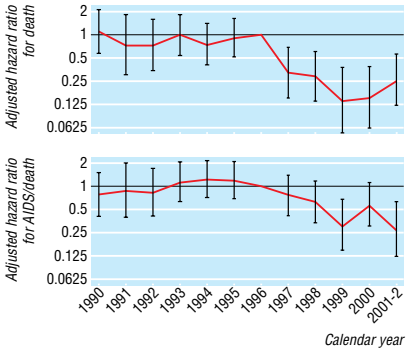
Competing interests: None declared.

1 Symmonds M, Matheson NJ, Harnden A. Guidelines on neuraminidase inhibitors in children are not supported by evidence. *BMJ* 2004;328:227. (24 January.)

Decline in mortality in children with HIV in the UK and Ireland



Risk of AIDS/death or death by year relative to 1996

Argument is flawed

Editor—The claims by Gibb et al, that their evidence shows a decline in mortality of children with HIV/AIDS in the United Kingdom and Ireland (thanks to antiretrovirals), cannot go unchallenged.[1] In their methods section they make little or no reference to the management of opportunistic infections. Furthermore, we have no idea how and where these children were delivered.

Were some of these children delivered by caesarean section? This may be important since some authors have asked whether the protective effect of caesarean delivery independent of zidovudine prophylaxis can be further investigated by a large, international, individual patient data meta-analysis of observational studies. A definitive answer to the question will require a randomised clinical trial, which is the only method to ensure that women who undergo an elective caesarean delivery do not differ from those with other types of delivery for any known or unknown confounding factor.[2]

Sixty seven per cent of the children in the paper by Gibb et al were of African parentage, but we are not given the dates when their parents entered the United Kingdom. Nutrition in Africa is known to be poor, whereas in the United Kingdom it is better and undoubtedly the immune status of these children must have been boosted.

A worrying trend alluded to in this issue of the *BMJ* is the decline in the number of randomised controlled trials.[3] Gibb et al make no mention of this.

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1 Gibb DM, Duong T, Tookey PA, Sharland M, Tudor-Williams, Novelli, V et al. Decline in mortality, AIDS and hospital admissions in perinatally HIV-1 infected children in the United Kingdom and Ireland. *BMJ* 2003;327:1019-31. (1 November.)
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HIV positive adolescents urgently need dedicated services

EDITOR—Gibb et al describe the dramatic impact of antiretroviral therapy in HIV-1 infected children.[1] Improved survival means that increasing numbers of HIV infected adolescents will confront issues common to this age group, such as poor outpatient attendance,[2] problems with adherence to treatment,[3] and transition to an adult environment.

The Intercollegiate Working Party on Adolescent Health supports the development of dedicated adolescent clinics.[4] In 2001 we established the first adolescent only HIV outpatient service in the United Kingdom. Young people were closely involved in the multidisciplinary clinic design, and a transition policy was developed together with the family unit at Great Ormond Street Hospital.[5] Our aim was to create an environment where adolescents felt able to discuss complex issues including antiretroviral therapy, sexual debut, social isolation, and familial bereavement.

Over the past two years 15 adolescents have transferred to the clinic. Most (13) are Black African. At the time of transition eight had an AIDS defining illness, and 13 required antiretroviral therapy, eight with a viral load <50 copies/ml. Seven of the 14 adolescents who have ever taken antiretrovirals have documented resistance to the drugs, and four of the 15 report being sexually active. No patients have been lost to follow up.

Increasing numbers of HIV infected children who have been treated with many drugs are reaching adolescence and becoming sexually active. We need dedicated adolescent services to minimise loss to follow up, encourage adherence to treatment with antiretrovirals and prevent transmission of drug resistant virus. As individual HIV units see only small numbers of adolescents, we should establish service networks with comprehensive guidelines to ensure best practice.

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1 Gibb DM, Duong T, Tookey PA, Sharland M, Tudor-Williams, Novelli, V et al. Decline in mortality, AIDS and hospital admissions in perinatally HIV-1 infected children in the United Kingdom and Ireland. *BMJ* 2003;327:1019-31. (1 November.)
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4 Royal College of Paediatrics and Child Health. Bridging the gaps: health care for adolescents. London: RCPCH, 2003.
5 Miles K, Prime K, Sudlow J, Kirkpatrick E, Clapson M, Penny N, et al. Bridging the gap between paediatric and adult HIV services. *HIV Med* 2003;4:21.

Authors' reply

EDITOR—Mhlongo and Maduna and Prime et al challenge the results of our study and think that we overlooked alternative reasons for the rapid fivefold decline in mortality, progression to AIDS, and hospital admission rates we reported in the CHIPS cohort of vertically HIV infected children in the United Kingdom and Ireland. We cannot agree that they provide viable alternative explanations for the dramatic reduction.

Firstly, we did not include details of management of opportunistic infections, and we agree that there is indirect evidence that cotrimoxazole prophylaxis reduces the frequency of these (particularly *Pneumocystis carinii* pneumonia in infancy, as previously reported in the United Kingdom[1]). This does not explain the magnitude or the timing of the effect we observed; cotrimoxazole prophylaxis has been widely used in HIV infected children in the United Kingdom and Ireland since the early 1990s, as evidenced by its inclusion in guidelines in 1994, which reflected established practice at that time.[2] No other significant change in the management or prophylaxis of opportunistic infections occurred around the time that combination antiretroviral therapy became available.

Secondly, we do not see the relevance of including details on mode of delivery as our paper related only to HIV infected children (the authors seem unaware of the published clinical trial that compared mother to child transmission rates after elective caesarean section *v* vaginal delivery[3]).

Thirdly, although we agree that the nutritional status of children in the United Kingdom and Ireland is much better than in Africa, we were not comparing survival of children in Africa with those here. Rather, we included children in the analysis of our cohort only after they had presented to medical services in the United Kingdom or Ireland (as detailed in the methods section). If anything, there might have been a bias towards poorer prognosis for the children presenting in more recent years who were more likely to be recent arrivals from Africa with advanced symptomatic disease.

Finally, we did not discuss clinical trials as our paper was about a cohort study. However, among paediatricians working with HIV infected children there is a strong tradition of enrolling children in clinical trials through the Paediatric European Network for Treatment of AIDS (PENTA).

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Competing interests: None declared.

1 Duong T, AE Ades, Gibb DM, Tookey PA, Masters J. Falling HIV vertical transmission rates in the British Isles: estimates based on surveillance data. *BMJ* 1999;319:1227-9.
2 CDC. Guidelines for prophylaxis against PCP in children with HIV. *MMWR Morb Mortal Wkly Rep* 1991;40:1-13.
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Treating major depression in children and adolescents

Research is needed into safer and more effective drugs

EDITOR—We report our preliminary findings on prescribing of antidepressants in general practice, in response to the recommendation by the regulatory agency for medicines and healthcare products to withdraw selective serotonin reuptake inhibitors from use in paediatric depression.[1 2]

We used the general practice research database to analyse use between 1 January 1992 and 31 December 2001 (88 522 prescriptions issued to 23 999 children and adolescents).[3] Fifty nine per cent of antidepressant prescriptions were for tricyclics; 39% were for selective serotonin reuptake inhibitors. The most commonly prescribed antidepressants were imipramine (25% of prescriptions), fluoxetine (19%), and amitriptyline (18%). Paroxetine, sertraline, citalopram, venlafaxine, and fluvoxamine accounted for 21% of prescriptions. Sixty three per cent, 35%, and 2% of patients were given tricyclics, selective serotonin reuptake inhibitors, and other antidepressants,


ALEX JAMES PHOTOGRAPH/C/PHOTONICA

respectively, as the first antidepressant prescribed.

In patients aged 10 years or younger the most commonly recorded indication for tricyclic use was enuresis (78%); in those aged 15 years or older it was depression (53%). In this older group, use of antidepressants was three times more common in girls than boys. In 1992 tricyclics were prescribed to nine times more patients than selective serotonin reuptake inhibitors; by 2001 twice as many patients received selective serotonin reuptake inhibitors than tricyclics.

Selective serotonin reuptake inhibitors gained popularity for the treatment of depression compared with tricyclics, but tricyclics were used commonly in nocturnal enuresis. These trends may change after the recommendation. However, tricyclics are ineffective in prepubertal depression, and there is marginal evidence to support their use in adolescents,[4] leaving an urgent need to research safer and more effective medicines for children and adolescents with depression.[5]

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ICKW's post is funded by a public health career scientist award from the Department of Health.

Competing interests: ICKW has received funding from various pharmaceutical companies including companies that produce selective serotonin reuptake inhibitors but none was related to this study.

1 Ramchandani P. Treatment of major depressive disorder in children and adolescents. *BMJ* 2004;328:3-4. (3 January.)
2 Committee on Safety of Medicines. *Selective serotonin reuptake inhibitors (SSRIs): Overview of regulatory status and CSM advice relating to major depressive disorder (MDD) in children and adolescents including a summary of available safety and efficacy data.* http://medicines.mhra.gov.uk/ourwork/monitorsafequalmed/safetymessages/ssrioverview_101203.htm (accessed 12 Dec 2003).
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4 Hazell P, O'Connell D, Heathcote D, Henry D. Tricyclic drugs for depression in children and adolescents. *Cochrane Database Syst Rev* 2002;(2):CD002317.
5 Wong ICK, Camilleri-Novak D, Stephens P. Rise in psychotropic drug prescribing in children in the UK – an urgent public health issue. *Drug Safety* 2003;26:1117-8.

Depressed adolescents may lose out

EDITOR—Ramchandani discusses the treatment of major depressive disorder in children and adolescents.[1] The conclusion of the Committee on Safety of Medicines is based on two premises: lack of effectiveness and increased risk of suicide.

None of the evidence stacks up. Even the paper of the Food and Drug Administration points out that the effectiveness of sertraline and fluoxetine is likely to be the same.[2]

Furthermore, it says that in all the organised trials, no completed suicide was reported. It also points out that in major depressive disease, suicide is a likely event anyway. (In any case, the correct management of depressed children entails suicide watch.) If the risk increases it is likely to only be at the beginning of treatment, when the disinhibiting effects of selective serotonin reuptake inhibitors are not yet balanced by improving mood patterns.

What I find most unsatisfactory is the failure to publish the data on which the conclusions are based. The Food and Drug Administration concludes that the trials to show effectiveness were possibly flawed and inconclusive. This is an example of jumping on the bandwagon of media scare stories, and its likeliest effect is to increase morbidity and suicide risk in children and adolescents.

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Competing interests: None declared.

1 Ramchandani P. Treatment of major depressive disorder in children and adolescents. *BMJ* 2004;328:3-4. (3 January.)
2 Food and Drug Administration. FDA issues public health advisory entitled: *Reports of suicidality in paediatric patients being treated with antidepressant medications for major depressive disorder (MDD).* Rockville, MD: FDA, 27 October 2003. www.fda.gov/bbs/topics/ANSWERS/2003/ANS01256.html (accessed 1 Feb 2004).

Use of selective serotonin reuptake inhibitors needs urgent clarification

EDITOR—Ramchandani's editorial focuses entirely on the use of selective serotonin reuptake inhibitors in the treatment of major depressive disorder, just as did the statements of the chairman of the Committee on Safety of Medicines on which he comments.[1] Did he not think it odd that the statement said nothing about obsessive-compulsive disorder, panic disorder, social phobia, or general anxiety disorder, for which various selective serotonin reuptake inhibitors are also prescribed?

The committee does not say whether the use of these drugs for these conditions in people under 18 is justified and appropriate. Presumably the committee's expert working group is considering these questions, but that requires a clear official statement now.

The *British National Formulary* notes the following indications[2]:

- Citalopram: panic disorder child not recommended (adolescent not mentioned)
- Escitalopram: child and adolescent under 18 not recommended (strange, since it is virtually identical with citalopram)
- Fluoxetine: bulimia, obsessive-compulsive disorder, child not recommended (adolescent not mentioned)
- Fluvoxamine: obsessive-compulsive disorder, indicated for children over 8
- Paroxetine: obsessive-compulsive disorder, panic disorder, social phobia, general anxiety disorder, child not recommended (adolescent not mentioned)
- Sertraline: obsessive-compulsive disorder, indicated for children over 6 and adolescents; post-traumatic stress disorder, child not recommended (adolescent not mentioned)
- Venlafaxine: general anxiety disorder, child and adolescent under 18 not recommended

It may be too late for the Committee on Safety of Medicines and Medicines and Healthcare Products Regulatory Agency to unravel this confusion in time for the March edition of the formulary, but that makes it especially urgent for them to issue a clear statement that will help prescribers, as well as patients and their parents.

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1 Ramchandani P. Treatment of major depressive disorder in children and adolescents. *BMJ* 2004;328:3-4. (3 January.)
2 British Medical Association, Royal Pharmaceutical Society of Great Britain. *British national formulary.* London: BMA, RPS, 2003(September):193-7.

Children and parents need better information on medicines

EDITOR—Bonati and Pandolfini write of the need for a European formulary aimed at helping those who prescribe for children or who dispense for or give drugs to them.[1] Better information about medicines for children is certainly needed.

Most medicines are given to younger children by parents and carers, whereas older children generally self administer. Since much of this is outside of current licensed indications, very little information is available to parents and children to help them make safe and informed choices about medicine taking. Drug companies are expressly prohibited from providing information for the public about unlicensed use of their products.

A new version of *Medicines for Children* or its equivalent is urgently needed, designed for children and parents, and written in clear, accessible lay language.[2] Ideally this would be available through the internet and potentially via interactive television, as well as in paper form. Such an innovation would be a valuable resource for patients and for health professionals, and would contribute to the safer and more effective use of medicines by children.

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1 Bonati M, Pandolfini C. Children need international formulary to guarantee rational use of drugs. *BMJ* 2004;328:227. (24 January.)
2 Royal College of Paediatrics and Child Health. *Medicines for children.* London: British Medical Association, 1999.