

## Introducing Dr Foster's case notes

This week's journal features the debut of Dr Foster's case notes, our new monthly page highlighting data from Dr Foster, an independent London based organisation that analyses the availability, quality, and costs of health care in the United Kingdom and globally. We aim to provide doctors, managers,

and patients with data about how various treatments and systems work in the real, messy world of clinical practice. Dr Foster uses administrative data such as hospital episodes statistics and self reported data collected from hospitals by survey. This month's Dr Foster's case notes reports that acute stroke units and early computed tomography scans are associated with lower in-hospital death rates.

### POEM\*

#### Risk of suicide in bipolar disorder is least with lithium

**Question** Which drug used to treat bipolar disorder is most effective for reducing the risk of suicide?

**Synopsis** The use of lithium in the treatment of bipolar disorder has decreased as the use of anticonvulsants has steadily increased. Consistent evidence shows that lithium is effective for reducing the risk of suicide, but little is known about other agents. In this retrospective cohort study, the authors wanted to compare the risk of a suicide attempt and death during lithium treatment with that during treatment with divalproex (Epival, Depakote) and carbamazepine (Tegretol). Data were obtained from two large managed care organisations in California on 20 638 members aged 14 years or older with at least one outpatient diagnosis of bipolar disorder and at least one filled prescription for lithium, divalproex, or carbamazepine. The mean follow up period was approximately three years per individual. Suicide attempts were identified by using emergency department visit and hospital discharge diagnoses. Suicide deaths were identified from health plan mortality records and death certificate reports. Because of the potential for confounding bias in analyses of large databases like this, the authors adjusted for age, sex, health plan, year of diagnosis, comorbid medical and psychiatric conditions, and concomitant psychotropic drug use. However, because of the retrospective study design, we can never be certain that confounding bias did not occur. The risk of suicide was 2.7 times higher (95% confidence interval 1.1 to 6.3) during treatment with divalproex than with lithium. Rates for non-fatal attempts were also higher during treatment with divalproex. Although the power of the analysis to evaluate carbamazepine was low, patients taking carbamazepine were more likely to be hospitalised for suicide attempts.

**Bottom line** The risk of suicide attempts and death in patients with bipolar disorder seems to be lower during treatment with lithium than during treatment with divalproex and carbamazepine. More reliable evidence is needed from prospective randomised trials that compare these drugs head to head and with others.

**Level of evidence** 2b (see [www.cebm.net/levels\\_of\\_evidence.asp](http://www.cebm.net/levels_of_evidence.asp)). Individual cohort study or low quality randomised controlled trials (<80% follow up).

Goodwin FK, Fireman B, Simon GE, et al. Suicide risk in bipolar disorder during treatment with lithium and divalproex. *JAMA* 2003;290:1467-73.

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\* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

## Editor's choice

### Abusing patients by denying them choice

A useful tip for smart arse medical students. If asked: "What is the treatment for x?" Don't answer: "y." Instead answer: "Whatever the patient chooses together with me after being fully informed of the pluses and minuses of all options." Giving patients choice in complex circumstances emerges as a theme in this issue—with the sombre overtone that not to give patients choice is to abuse them.

It first hit me that denying patients choice is a form of abuse when about six years ago I read a paper on patient choice in screening for colorectal cancer. One hundred Californian patients were given full information on five options: nothing, faecal occult blood testing, barium enema examination, flexible sigmoidoscopy, or colonoscopy. Patients were told about the nature of the test, the preparation required, the need for sedation, the time required, how often the test would be repeated, the likely results with both positive and negative outcomes in detail, and the cost. The result was that patients chose very different options.

Steve Woolf, a family physician and North American editor of the *BMJ*, wrote: "Suppose these same 100 patients had not received this information and were instead cared for by a physician who routinely performs flexible sigmoidoscopy because he considers it the best test. According to these data, fully 87% of the patients would undergo a procedure other than the one they would prefer if properly informed" (*J Fam Pract* 1997;45:205-8). Nine out of 10 patients have been abused.

Mark Sculpher and others describe how they used something called a discrete choice experiment to help men with non-metastatic prostate cancer to choose between different options for treatment (p 382). The main conclusions are that men are willing to engage in this complex process and will trade life expectancy in order to avoid side effects. Mandy Ryan discusses how the technique can be used in other circumstances (p 358).

Some 15-20 years ago an editorial in the *BMJ* suggested that every menopausal woman should have hormone replacement therapy. That now looks like bad advice not only because therapy increases the risk of breast cancer, heart disease, and thrombembolism but also because only women themselves can trade off how they value the benefits and risks. A group from Leicester present a detailed decision analysis of the harms and benefits of therapy in the light of the latest evidence and conclude that two important variables are perceived symptoms and baseline risk of breast cancer (p 371). Klim McPherson weighs up hormone replacement therapy and also draws lessons from the whole sorry story of the mass drugging of women for largely non-existent benefits (p 357).

The main arguments against fully informing patients are that "It's too difficult, costly, and time consuming." But they are neither evidence based nor politically sustainable.

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