It is important to follow evidence-based medicines advice but also to be aware of its limitations

Medicines for the management of pain are commonly prescribed but the control of pain remains a problem for many patients. In this month's *Pharmacy in Practice* Janice Moorekite (p92) considers how to review prescriptions for pain management.

Medication review of pain medicines is important for a number of reasons. Firstly, many patients do not take sufficient doses for effective analgesia because of concerns about side-effects and tolerance.[1] Only a face-to-face review can identify how medicines are being taken. Secondly, all analgesics cause side-effects, such as constipation with opiate-based analgesics and precipitation of renal failure, congestive cardiac failure, thrombo-embolism and GI bleeds with NSAIDs. After many years of advising against the use of topical NSAIDs pharmacists might be amused, horrified or even glad that NICE are now recommending them before the use of oral NSAIDs in osteoarthritis.[2] What is perhaps disappointing is that rubifacients and glucosamine are not recommended by NICE. This is because of lack of data on efficacy rather than evidence that they do not work. The placebo effect on pain has been known about for a long time.[3] Rubifacients and glucosamine, being

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relatively harmless, inexpensive and popular with patients, are therefore worth having available for treatment despite lacking clinical evidence.

In the first of two articles on the management of depression Stephen Bleakley (p84) looks at the principles of recognising and managing depression. The treatment options are reviewed. Whether antidepressants are more effective than placebo has been brought into question lately.[4] The definition of effectiveness is based on something called 'effect size'. Two meta-analyses of antidepressant studies[4,5] found effect sizes of 0.32 and 0.31 respectively. The first study concluded they were *ineffective*, while the second considered them *more effective* than placebo. Kirsch and colleagues[4] concluded that antidepressants were *ineffective* because the criterion for effectiveness defined by NICE of 0.5 was used.

Effect size is designed to describe the *size* of an effect (*clinical* significance) and not to say *if* it is true or not (*statistical* significance). So, the correct interpretation of the data is that antidepressants are effective but have only a small benefit compared to placebo.

NICE do not recommend initial antidepressant treatment for mild depression because the risk:benefit ratio is poor.[6] However, antidepressants remain highly effective for many patients and clinicians using antidepressants judge the response to treatment on an individual basis. And, of course, the severity of depression needs to be taken into consideration when making a prescribing decision.

In this month's *Therapeutic options* Dr Martin Duerden (p80) considers whether we should be trying to achieve greater reductions in low density lipoprotein (LDL) and total cholesterol than we currently aim for. The evidence for treating to lower targets is small or non-existent for patients with 'lower levels' of risk or for primary prevention. There is a stronger case for aggressively treating higher risk conditions such as acute coronary syndrome.

The evidence shows that taking a statin is the most important objective despite the baseline level of LDL or total cholesterol. In the UK there are still many patients with established CHD, diabetes and a CV risk of more than 20% who are not prescribed statins. Health inequalities remain — especially in inner city areas and for ethic minority populations. Also it is likely that

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some patients with established CV disease and diabetes are not being prescribed a statin because their cholesterol level is not above 5mmol/l, which is an arbitrary value. Clinical pharmacists should be ensuring eligible people are prescribed statins before chasing lower targets.

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