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Letter to the Editor re: "Medicine and its Preventive Excesses"

Carta ao Editor re: "Medicina e os seus Excessos Preventivos"

Keywords: Medical Overuse; Preventive Medicine; Public Health
Palavras-chave: Medicina Preventiva; Saúde Pública; Uso Excessivo de Produtos e Serviços de Saúde

Promoting health and preventing disease are common endeavours of all physicians. Juan Gérvas reminds us again that prevention should only be implemented if there is high quality evidence that the benefits of prevention surpass its harms.[1] He also reminds us of the ethical and epidemiological differences between the curative and preventive contract,[2–4] and these differences are worth emphasising.

In curative medicine, harm and benefit coexist in the same patient. Consider treatment with nonsteroidal anti-inflammatory drug (NSAIDs) for rheumatoid arthritis. The patient who has an NSAID-induced GI-bleeding is the same that experienced a reduction in arthritis symptoms. Contrast this with lung cancer screening. The individual whose life is saved by earlier detection of her lung cancer is not the same individual who requires a bronchoscopy to exclude cancer after a false-positive screening test. So, a preventive intervention may have a favourable benefit harm balance at the population level, but the individual patient we offered prevention can suffer net harm.[2] This is a first argument to support the idea that preventive interventions need high quality evidence that they are safe.

One of the teachings of clinical epidemiology is that the probability of benefiting from an intervention depends on the baseline risk of a poor outcome. Consider acetylsalicylic acid (ASA) for prevention of cardiovascular disease.[5] In people with previous cardiovascular events, for every 1000 patients treated with ASA for 10 years, 150 avert a second cardiovascular event. Contrast this with people with no previous cardiovascular events. For every 1000 people treated with ASA for 10 years, 6 avert a second cardiovascular event. A striking difference from curative to preventive medicine is that the percentage of patients that benefit from a curative treatment is much larger than the percentage of patients that benefit from a preventive treatment. In addition, it is estimated that for 1000 people treated with ASA for 10 years, 3 will experience a major gastrointestinal bleeding. It becomes clear that the larger the baseline risk of cardiovascular event, the more favourable is the balance of benefits and harms antiplatelet treatment with ASA. This relationship is valid for most preventive interventions. This is a second argument to support the idea that preventive interventions need high quality evidence that they are safe.

In clinical practice it is easy to forget the differences between the curative and preventive contract, especially now when the lines between and the other are blurred (e.g. the treatment of hypertension, osteoporosis, cervical intraepithelial neoplasia). We should thank Juan Gérvas for this opportunity to pause and think about our everyday practice.

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