and the patient was treated with sunitinib with prompt response in all sites of disease.

We have described two patients in whom the diagnosis of metastatic urological cancer was conveniently, efficiently and quickly made by using EBUS-TBNA. To our knowledge, there is only one published report of metastatic renal cancer being diagnosed using this technique1 and no reports of metastatic prostate cancer being diagnosed using EBUS-TBNA. Mediastinal lymphadenopathy is often found in both malignant and benign conditions, and in the vast majority of cases, accurate tissue diagnosis is essential. The traditional gold standard method to evaluate mediastinal lymphadenopathy of uncertain aetiology is mediastinoscopy, although this procedure is associated with drawbacks. For example, standard cervical mediastinoscopy can usually only sample lymph nodes at stations 2 (upper paratracheal), 4 (lower paratracheal) and 7 (subcarinal)2 of the Mountain and Dresler classification,3 while nodes at the lower aspect of the subcarinal area can be difficult to access. Its sensitivity, specificity and sampling strategy can also be variable.4 Although generally safe, mediastinoscopy carries a small but appreciable complication rate,5,6 and it cannot be easily repeated in the same individual. In summary, our two reports highlight the importance of clinical awareness of EBUS-TBNA across the spectrum of medical and surgical disciplines in the evaluation of undiagnosed mediastinal lymphadenopathy, without the need for mediastinoscopy.

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Advance Access Publication 11 January 2012

Questionable summaries of questionable evidence

Sir,

I note that a recent QJM review article1 on anticoagulation in atrial fibrillation included in its list of authors Dr Leach, an employee of Chameleon Communications International. Dr Leach’s involvement in the article was funded by Bayer who make Rivaroxaban, one of the drugs discussed in the article. Professor Hobbs, the co-author, has received speaker fees and sponsorship in the past from a number of manufacturers of new oral anticoagulants. Chameleon Communications has been involved in preparing numerous other manuscripts in other journals on new anticoagulants over recent months.2–4

A second paper on new oral anticoagulants by Professor Kreuzer appeared in the same edition of QJM.5 ‘Editorial assistance’ on this paper was provided by a company called PAREXEL and funded by Boehringer Ingelheim, manufacturers of Dabigatran etexilate, a drug promoted in the article’s conclusion.

Clearly, the involvement of industry in the funding of review articles generates bias, probably above and beyond the mere choice of topics on which they focus. I think it would be helpful to have answers to the following questions.

From Dr Leach—what is your expertise in this field? From Chameleon Communications and
PAREXEL—are you able to highlight any published work with which you have assisted that recommends not prescribing a drug manufactured by the sponsor of the work? From the sponsors, PAREXEL or Chameleon Communications—would you be willing to make public the agreements or contracts between your organizations pertaining to these QJM papers? From the editors—did you attempt to source an independent review on this topic and, if not, why not?

How long are we going to put up with a situation where our practice is informed by biased evidence summarized for us by people who have financial relationships with companies set to profit from alterations to our practice? These flagrant conflicts of interest would not be tolerated in other industries. We need to get our house in order.

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References

Notes from the Editor
The editor would wish to thank Dr Yates for raising this important issue. I can reassure the readership that both papers referred to in Dr Yates’ letter were subjected to independent and rigorous peer review before being accepted for publication. The issue of conflicting and competing interest is a complex area in medical publishing. Good practice dictates that all authors declare any potential competing interest and, as Prof Hobbs has stated in his response, this has been undertaken.

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Advance Access Publication 30 December 2011

Challenges of anticoagulant therapy in patients with atrial fibrillation in clinical practice

Sir,

Dr Yates objects that the authors have potential conflicts of interest to declare and implies that the review is automatically biased as a consequence, though he does not state what material he considers inaccurate or imbalanced. In this paper, both the co-authors have declared their interests fully, including explicitly to pharmaceutical companies that have interests in anticoagulation. Dr Leach has the more direct competing interests in the drafting of the paper, but this is stated clearly.

The paper covers a therapeutic area of great and increasing importance—stroke prevention in atrial fibrillation—which is obviously further enhanced by the appearance of the first new drugs in the area for 50 years since warfarin. Surely Dr Yates does not think that the paper should not have mentioned the emerging evidence base for these novel agents in addition to reviewing the data and associated usage of warfarin and aspirin? The general under-management of stroke risk (use of Vitamin K antagonists in those deemed at high stroke risk and therefore should be offered anticoagulation is <50% in most countries) is an important topic and the relative lack of efficacy of the anti-platelet aspirin, often offered by clinicians as an alternative to anticoagulation, has resulted in a re-evaluation of its role in recent AF guideline updates.

The paper underwent independent review by the Journal and the authors responded to feedback. If the paper had not been assessed as a balanced review it would not have been accepted for publication.

Inevitably, competing interest is a complex subject since authors may or may not be conflicted by them. What is important is that they are stated so that the reader can judge whether they