

such as changes in blood pressure or cholesterol. There is a continuing debate about the adequacy of surrogate end-points, but even their defenders concede that the surrogates have not proved to be reliable predictors of outcome in a number of cases.<sup>6</sup> While journal advertisements are nominally restricted to claims based on these surrogate end-points more expansive claims are often implied. For instance, although cerivastatin was only indicated for cholesterol reduction a 2000 advert in the Australian Family Physician stated that it was as 'strong as an ox' and a 'powerful treatment' possibly leaving the implication that the drug did more than just lower cholesterol.

Finally, there is evidence that data on new drugs which comes from the manufacturer, may be biased. A recent meta-analysis of research analysing the effects of industry funding found that studies funded by pharmaceutical companies were more than four times more likely to produce positive results than those with other sources of sponsorship.<sup>7</sup>

Given the lack of evidence that most new drugs provide any therapeutic advantage over existing treatments, what should general practitioners do? On average, patients will be better off if general practitioners avoid using new drugs until they have been available for more than five years, unless there is strong evidence of superiority over established treatments. Since doctors cannot rely on company promotion to identify this group of drugs, where should they turn? The best sources are the independent drug bulletins and books that not only provide an objective evaluation about individual drugs but also compare drug therapies. Australia is fortunate to have a number of such

sources including *Australian Prescriber*, Therapeutic Guidelines and the Australian Medicines Handbook.

At the very least doctors need to avoid being rushed into using new drugs by siren calls from the pharmaceutical industry.

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*Conflict of interest: none declared*

## Letters

Letters, which may not necessarily be published in full, should be restricted to not more than 250 words. When relevant, comment on the letter is sought from the author. Due to production schedules, it is normally not possible to publish letters received in response to material appearing in a particular issue earlier than the second or third subsequent issue.

### Dental patients taking warfarin

Editor, –The management of patients taking anticoagulants who require dental extractions is of interest to both medical and dental practitioners.<sup>1</sup> It has been common practice to discontinue anticoagulants to reduce the risk of post-extraction bleeding. Lately however some studies have questioned the need for reduction or withdrawal of warfarin when the INR was within the therapeutic range.

We have recently reported a study involving 70 patients who were taking warfarin for a variety of medical conditions and required dental surgery.<sup>2</sup> A control group of 35 patients stopped their warfarin before their minor oral surgery while the other patients continued treatment (INR 2–4). Local haemostatic measures were only used when the procedure involved removal of bone or soft tissue surgery.

There was no significant post-treatment haemorrhage in either group. This suggests that patients can safely undergo

minor oral surgical procedures without alteration to their therapeutic anticoagulant regimen. This reduces the risk of thromboembolic episodes occurring when the warfarin is stopped.

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