Unhealthily close links between the various experts or authorities

The Mediator° scandal and the debates it provoked made the general public aware of the concept of conflicts of interest: because influential individuals work both on behalf of the pharmaceutical industry and for the drug regulatory agency, they are simultaneously judging and being judged. Beyond the concept of conflicts of interest, drug regulatory agency decisions are also influenced by the unhealthily close links between their staff or experts and industry representatives.

Tacit compromise, possibly unconscious, but always kept secret, is a standard method of decision-making in these committees and working groups. They do not have to disclose the details of their discussions, their arguments, the evidence they used, or their votes. Especially when some internal rule or usual practice states that the goal is to reach “consensus”. How many potential whistleblowers have been gagged by the pursuit of consensus?

Too much biased consensus. Consensus is even harder to break when the decision-makers, representing healthcare administrators, pharmaceutical companies, government, health professionals and even patients, have all known each other for a long time. They often obtained the same qualifications from the same universities, belong to the same socioeconomic classes and the small circle of experts, etc. It would take real courage and motivation to dare to speak out in such meetings.

A decisive element for ensuring that the quiescence, consensual decision-making does not become the norm, is the transparency of the meetings. But frequent and regular change in the various representatives who sit on the committees is also essential, extending recruitment to other circles and other countries.

At a different level, the same people can successively occupy positions of power in government ministries, pharmaceutical companies, drug regulatory agencies, then return to the pharmaceutical industry. This revolving door is often detrimental to patients and beneficial to the pharmaceutical industry. Going back and forth between these different positions is unacceptable.

The truth, the whole truth

In addition to the necessary improvements to the practices of the pharmaceutical industry and regulators, the Mediator° scandal will only lead to last- ing improvements if healthcare professionals, patients, experts and authorities change some of their attitudes: basing their actions on critical appraisal of scientific evidence; making shared, transparent decisions; paying more attention to adverse effects; avoiding the blurring of roles and unhealthily close links between those in authority.

Through the Mediator° scandal, Prescrire has become better known, achieved greater prominence, and has been able to promote some of the guiding principles it has upheld for the past 30 years, reflected in the following suggestions:

− to endeavour to give as small a role as possible to hope that is not grounded in solid evidence: to reach conclusions on the basis of evidence, i.e. after examining the facts, as opposed to assumptions and wishful thinking;
− to tell the truth to patients and the public.

European Medicines Agency: complete transparency needed

− Trial protocols and raw data.

The experience of two medical research scientists from the Nordic Cochrane Centre in Copenhagen shows that, as of 2011, the European Medicines Agency (EMA) still lacks transparency and works first and foremost for the pharmaceutical industry (1).

The EMA obstructs access to clinical data. In 2007, while the EMA was examining the marketing authorisation applications for rimonabant (formerly marketed under the brand name Acomplia°) and orlistat (Xenical°, Alli°), the two scientists requested the complete clinical trial reports and protocols of 15 placebo-controlled trials of these two drugs (1).

The scientists wanted to check the robustness of the results and measure any discrepancy between the published and unpublished data. The information requested “was important for patients because anti-obesity pills are controversial. The effect on weight loss in the published trials is small, and the harms are substantial (...), and most of the drugs have been deregistered for safety reasons” (1).

After several refusals from the EMA’s director, who went as far as demanding evidence that the requested documents were of major public interest, the...
scientists lodged a complaint with the European ombudsman. The EMA persisted in refusing access to the data until the ombudsman accused it of “maladministration”. The EMA finally released the documents 3 years after the initial request and 2 years after marketing authorisation for rimonabant had been withdrawn.

This is not an isolated event (2, 3). The EMA often uses the same pretexts to refuse Prescrire’s requests for access to clinical data, i.e. that the company’s commercial interests must be protected or that a European review of the drug is underway (3). In May 2011, the EMA again refused to provide Prescrire with data on the risks of bladder cancer associated with pioglitazone (Actos®) (4).

Demand transparency, in patients’ best interests. Access to assessment reports is not enough. What is needed is access to data covering all of the results and all of the trial protocols, as the Cochrane Centre scientists requested. It is high time the EMA decided to hide nothing, be it from scientists, healthcare professionals or patients.

Selected references.
1- Gøtzsche P and Jørgensen A “Opening up data associated with pioglitazone (Actos®)” (4).

Conclusive statement and to highlight a number of points. [Editor’s note: in the following text, the subtitles in bold were added by Prescrire]

A frequent problem; indisputable assessment. “Allergic rhinitis is a global public health problem, affecting more than 500 million people worldwide. Its frequency is increasing, and has risen by a factor of 3 or 4 over the past three decades (2). Given the magnitude of this problem, experts of the ARIA group (Allergic Rhinitis and its Impact on Asthma) have been working in collaboration with the World Health Organization since 1999 to establish evidence-based guidelines (based on robust, controlled and randomised clinical trials) (2). They have concluded that allergen desensitisation (now called allergen-specific immunotherapy) is effective, in combination with other measures: allergen avoidance, symptomatic drug therapy (2). Several systematic reviews and meta-analyses published by the Cochrane Collaboration had already established the efficacy of allergen desensitisation in allergic rhinitis (see reference 3). The heterogeneity of the results of these studies was unavoidable, owing to design differences (allergen extracts, primary endpoints analysed, treatment duration, etc.). Large phase III trials were therefore necessary, and were conducted to evaluate two sublingual allergen-specific immunotherapy tablets containing grass pollens, in both adults (4, 5) and children (6, 7).”

The Prescrire article to which the letter from the French Society of Allergology refers is the Prescrire Patient Info sheet entitled “Allergic rhinitis: no routine desensitisation” published in French on the Prescrire website (www.prescrire.org). The information contained in this overview was drawn from several previous reviews conducted by Prescrire, including “Rhinite allergique saisonnière” and “Timothy pollen (standardised allergenic extract). Hay fever: 4 months treatment for 4 days’ relief?” published in 2007 in French (2008 in English), and “5-grass pollen mix. 4 more grass species, but still no progress” published in June 2010 (2011 in English) (11-13).

Today, in mid-2011, what is the evidence supporting the efficacy of sublingual desensitisation?

**Several months’ treatment for a few days’ benefit**

Seasonal allergic rhinitis (hay fever) is a benign condition, but the discomfort it