Curiosity

How is it that the link between *benfluorex* (formerly marketed under the brand name Mediator®) and heart valve disease was unrecognised for decades by most French cardiologists? Despite the drug's widespread use, the frequency of these valve disorders, and constant advances in echocardiography?

Admittedly it always takes time to integrate new information into what was already known. It also takes time to properly assimilate this information and change the way we practise. Especially when this information concerns adverse effects that have come to light over a period of years, sometimes long after the drug's market introduction.

For example, it has been known since the 2010s that *diclofenac* is associated with a higher incidence of serious cardiovascular effects than other nonsteroidal anti-inflammatory drugs (NSAIDs), yet it is still often used a decade later. Similarly, the knowledge that certain so-called selective serotonin reuptake inhibitor antidepressants (SSRIs) carry a higher risk of serious arrhythmia than others has so far had little effect on many doctors' prescribing behaviour.

This is partly due to the time it takes for a reassessment of the data and for updated practice guidelines to reach doctors, all more or less subject to influence. At a personal level, doctors may also be set in their ways or fail to keep their knowledge up to date.

But there was an additional factor at play in the case of heart valve disease induced by *benfluorex* (see p. 161 of this issue). As rheumatic fever is a classic cause of acquired valvular insufficiency in adults, many cardiologists saw this as the cause of the valvular insufficiency they observed in patients taking *benfluorex*. But how did they reconcile this diagnosis with the fact that rheumatic fever had disappeared in France, and that these patients had no history suggestive of a prior episode of acute rheumatic fever? By postulating a new form of rheumatic fever that goes unnoticed apart from its cardiac effects, a widely accepted theory that offered an explanation consistent with the principles taught in cardiology. No need to implicate a drug. No need to call a medical treatment into question.

How can we avoid these types of blind spots in the future? By approaching the search for explanations without bias or conformity. By systematically asking ourselves: could a drug have caused this? By taking care to remain curious, critical, attentive and open-minded when observations do not fit with existing data and principles.

Curiosity is an admirable quality!

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EDITORIAL