

ommended using HPV testing because it would lead to fewer visits to the primary care provider. We further reasoned that with less than three years since first vaginal intercourse it would be highly unlikely that an HPV infection once established would have led to a high grade lesion.

There are no Canadian guidelines yet that appropriately take into account HPV testing. The Pan-Canadian Forum on Cervical Cancer Prevention and Control³ has provided a fast-track opportunity to generate such evidence in the context of our country's screening programmes. In the meantime, however, we believe that the algorithms we proposed are a scientifically and clinically cogent management option.

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Not all guidelines are created equal

I have read with interest the recent editorial criticizing the Canadian Diabetes Association (CDA) Clinical Practice Guidelines (CPGs).¹ I am one of the few physicians who have served on both clinical practice guideline groups and drug review panels (in my case the CDA and Canadian Hypertension Education Program [CHEP] guideline groups and the

Ontario Drug Programs Branch Pharmacoeconomic Review Committee respectively). The mandate of guideline groups and drug review panels differ so extensively that one should expect that their respective conclusions will often differ. Guideline groups advocate use of the most effective therapies as suggested by the medical literature, and typically do not perform economic analyses when generating guidelines. Drug review panels determine whether a new therapeutic is sufficiently cost-effective and has an acceptable budget impact within the context of their jurisdiction. There are 4 primary reasons why guideline groups do not (and in my opinion should not) perform economic analyses when generating guidelines. First, guideline groups do not have a mandate from any provincial or federal agency to make decisions about what therapies will be publicly funded. Equally important, they have no mandate to recommend removal of currently funded therapeutics when the cost-effectiveness of care would benefit from such an action. Second, guideline groups are not provided projected budget information that would help inform an economic assessment. Third, one could consider an assessment of effectiveness to be somewhat "universal." In contrast, the determination of whether a therapy is acceptably cost-effective can certainly vary between jurisdictions. Finally, an economics based approach would place guideline groups in a true conflict of interest between their patient advocacy role and their obligations to the health care payors. It is important to recognize that the quality of the health economics section of a company's approval application could be lower than the clinical section, which could affect the subsequent conclusions about the drug.

The roles of guideline groups and drug review panels are both necessary and complimentary. Recognizing that the most effective therapies will not always be the most cost-effective leads to the appropriate expectation that guideline groups and drug review panels may reach opposite conclusions. The potential for dualities of interest is real, and guideline groups have processes in place to allow for declarations of potential conflicts. Making these declarations accessible to reviewers is a reasonable re-

quest. I would also suggest that making available the guideline's technical documents would be helpful in explaining how a literature review led to a specific guideline, and would mitigate criticism that self-interest motivated particular recommendations. CPGs are an essential resource for clinicians. Allowing reviewers to be aware of potential conflicts of interest is reasonable. Excluding publication of guidelines because potential conflicts of interest may exist is not.

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REFERENCE

1. Clinical practice guidelines and conflict of interest [editorial]. *CMAJ* 2005; 173(11):1297.

Competing interests: Dr. McFarlane has been involved in continuing medical education events and/or advisory boards that have been sponsored by companies that sell insulins in their product lines, including Sanofi-Aventis, the maker of insulin glargine.

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A recent *CMAJ* editorial drew attention to the potential for conflicts of interest to influence the development of clinical guidelines.¹ While we share your concerns, we wanted to register our disagreement with the *CMAJ* editorialist's conclusion that the only way to reduce potential conflicts of interest is to mandate that guideline panels consist only of non-experts. We believe strongly that clinical expertise in a particular area is necessary to properly interpret evidence related to that area.

We believe that the best solution to the dilemma raised by your editorialist is to ensure that guideline panels develop a transparent system of checks and balances that ensures both the integrity of the process and the quality of the recommendations made. To that end, we would like to point out that the hypertension recommendations produced by the CHEP are developed annually by experts from a variety of disciplines, none of whom are paid for their CHEP activities, and the following steps are taken to minimize potential biases:

1. An independent steering committee (consisting of representatives of the

Canadian Hypertension Society, Blood Pressure Canada, the Heart and Stroke Foundation of Canada, the Public Health Agency of Canada, the College of Family Physicians of Canada, the Canadian Council of Cardiovascular Nurses, and the Canadian Pharmacists Association) oversee the process.

- Clinical experts work with a Cochrane librarian to systematically identify and review the evidence in each topic area, and a central review committee of 4 methodologists reviews all of the evidence and recommendations prepared by these clinical experts. While clinical experts may receive funding from the pharmaceutical industry for advisory panels, consultants, or speakers bureaus, the members of the central review committee explicitly do not.
- All draft recommendations that are developed by the clinical experts for that topic and the central review committee to meet pre-specified levels of evidence are presented to and debated by the Recommendations Task Force of CHEP (44 unpaid volunteers with academic and clinical expertise in hypertension).
- The potential conflicts of interest of all members are identified, disclosed in writing and distributed at the consensus conference, and members with significant conflicts of interest are asked to abstain from votes on recommendations related to their potential conflicts.
- Only those draft recommendations supported by 70% or more of the Recommendations Task Force members are subsequently accepted.
- Although CHEP does receive funding from multiple sources to cover the costs of developing and disseminating the guidelines, the largest single financial sponsor of CHEP activities in 2005 was the Public Health Agency of Canada.

Although the *CMAJ* editorial suggests that more expensive antihypertensive therapies have been recommended over less expensive alternatives in Canada, we feel it important to point out that diuretics have been recommended as first-line drug therapy for hypertension in every iteration of the Canadian national hyper-

tension recommendations over the past three decades (including a period when international guideline panels had recommended against them). Indeed, in our listing of appropriate choices for first-line therapy, thiazide diuretics are the only drug class assigned a grade A recommendation.² Further, the percent increase in prescriptions for diuretics has increased dramatically and more than the increases for angiotensin-converting enzyme inhibitors or calcium channel blockers since the CHEP program started.³

Norm Campbell

Chair
CHEP Executive Committee

Finlay A. McAlister

Chair
Central Review Committee
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DOI:10.1503/cmaj.106008

[The editor responds:]

I commend the CHEP for its efforts to reduce bias resulting from financial competing interests when developing guidelines. The steps outlined in their letter lead in the right direction. In our editorial¹ we did not claim, as stated by Campbell and McAlister, that “guideline panels should consist only of non-experts.” Clinical expertise (especially if financially unencumbered) is important, especially in choosing meaningful clinical questions for randomized trials and in selecting endpoints for efficacy and adverse events. Analysis of the resulting data and summations of that data across multiple clinical trials (meta-analyses, evidence reviews of all sorts and guideline recommendations) are much more dependent on methodological expertise. Indeed, recommendations of clinical experts and of guidelines supported by

sponsors with commercial interests are heavily biased toward those interests.²

John Hoey

Editor
CMAJ

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DOI:10.1503/cmaj.060245

Corrections

Reference 10 in a recent commentary¹ was incorrect. The reference should have read as follows: Shah T, Casas J, Cooper J, et al. Insight into the nature of the CRP-coronary event association using Mendelian randomisation [abstract]. *Atherosclerosis* 2005;6(Suppl):78.

REFERENCE

- Lowe GDO. The association between elevated levels of inflammation biomarkers and coronary artery disease and death. *CMAJ* 2006;174(4):479-80.

DOI:10.1503/cmaj.060246


In a public health article on tuberculosis (TB),¹ there was a transcription error in the legend for Figure 1. The caption for TB cases 0–24 should have been cases/100 000 population/year, not cases/year.

REFERENCE

- Murray S. Challenges of tuberculosis control. *CMAJ* 2006;174(1):33-4.

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