Compassion for the worried and sometimes grief stricken individual will occasionally mislead a physician—encouraged by the person at risk—to recommend an intensified surveillance programme even though little evidence exists to endorse this. Although this may comfort the affected person and his or her family, the possible medical risks and socioeconomic consequences of an intensified surveillance programme must be borne in mind.

For responsible patient guidance, we have to detach ourselves from the individual case to a certain extent and, keeping Goethe's words in mind, take a look at the big picture. Only if we are able to merge the recent diagnostic advances in familial colorectal cancer with its clinical presentation will we be able to provide better recommendations for adequate surveillance of patients at variable risk of colorectal cancer. Then, indeed, we will have gone from bench to bedside.

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Information for patients on medicines

Should be much more accessible and patient centred

The traditional model for communicating with patients about their medicines is that doctors decide the best treatment and patients follow their doctors' instructions with only limited independent access to information about treatment. The Association of the British Pharmaceutical Industry (ABPI) is now reviewing its code of practice,¹ and this is an important opportunity to move to a more modern view of patients—as partners of health professionals and decision makers in relation to their health. The main aim of the code is to protect patients from potentially harmful influence. It currently focuses heavily on regulating the pharmaceutical industry's communications with health professionals and imposes highly restrictive conditions on direct communication with patients. This model is seriously flawed.

The ABPI code of practice should reflect the increasing role that patients are taking in decisions about their health and treatment, as well as patients' entitlement to access information from any source they choose. The code should require companies to provide better information for members of the public who seek it, rather than prevent them from doing so. It should focus on ensuring the objectivity, quality, and evidence base underpinning such information. The ABPI should police these standards rigorously.

Around half of all medicines are not taken as prescribed,² with serious consequences in terms of preventable ill health, mortality, and cost to the NHS. Non-compliance is almost always the result of conscious choices made by patients rather than forgetfulness.³ The best predictors of compliance are patients' attitudes, beliefs, and perceptions about their illness and treatment.⁴ These include whether patients perceive a medicine as necessary for maintaining health as well as concerns about possible adverse consequences such as unpleasant side effects, dependency,

or long term harm. These beliefs are strongly influenced by the information that patients receive from health professionals and other sources.

In all demographic groups, most patients want to take at least some part in decisions about their treatment, and value having information about medicines from different sources.⁵ Information about the potential risks and benefits of different options for treatment must be available to patients and their families in accessible formats. The quality of the patient information leaflets that come with prescribed medicines is improving,⁶ but these leaflets are regulatory documents and as such will always be too narrow, too negative, and too late to meet all patients' information needs (Raynor DK, British pharmaceutical conference, Harrogate, September 2003). More user friendly information needs to be available before the decision to prescribe is made, to support the shared decision making that patients say they want.

Pharmaceutical companies should have a controlled but greater role in providing patients with factual, unbiased, and non-promotional information about the risks and benefits of their medicines, both in response to individual inquiries and more generally. The restrictions in the current ABPI code make companies wary of doing so. Companies feel that the rules governing information for patients are insufficiently clear about what they can and cannot do, and this hinders them from acting in patients' interests.

In response to individual inquiries, companies will usually refuse to give anything but the most basic information and will not, for example, provide patients with copies of research papers even when these are specifically requested. This is unduly restrictive, as is the requirement that information may be given only for medicines "prescribed for the enquirer." In our view, any member of the public is entitled to question a

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company about any of its products, whether or not the person has been prescribed the product. Companies should be allowed and, indeed, required to provide factual and unbiased answers to patients' questions and to document inquiries and responses for public examination in case later queries arise.

The Medicines Information Project has shown that the pharmaceutical industry can develop information for patients and the general public about medicines, under the direction of a multisector board that includes patients' organisations, health professionals, and the medicines regulator.⁷ This information covering all medicines prescribed in the United Kingdom is being produced in a form called Medicine Guides, starting with treatments for asthma and chronic obstructive airways disease.⁸

Feedback about the pilot guides showed that they help patients and their families. Designed and developed with both health professionals and patients and accessible online from anywhere in the world, these guides have advantages over mandatory patient information leaflets. They can be customised to provide only the information relevant to a specific indication; they discuss medicines in the context of all available alternatives, including non-drug options; and they link to relevant clinical information about conditions in NHS Direct Online. And because the guides are an online resource with open access, they

can inform the dialogue between patients and health professionals when making treatment decisions.

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Adjuvant trastuzumab for breast cancer

We need to ensure that equity exists for access to effective and expensive treatments

In an era when encouraging headlines for the treatment of cancer seem to come and go, the results of randomised trials of adjuvant trastuzumab for treating breast cancers that overexpress human epidermal growth factor receptor 2 (HER2) have been rightly viewed as "stunning."¹ The implications are relevant not only to patients with respect to significantly reducing the risk of cancer recurrence and death but also to all involved in the delivery of health care. We need to ensure that the process for funding of these highly effective treatments remains equitable not only between patients with different types of cancer but also between patients in different countries.

HER2 normally helps in the regulation of cell proliferation. Amplification of the HER2/neu oncogene occurs in 25–30% of human primary breast cancers and portends a poorer prognosis.² Trastuzumab is a recombinant humanised monoclonal antibody directed against HER2. The success of trastuzumab is an example of true bench to bedside research. Rapid translation of experimental models led to groundbreaking results, initially in HER2 positive metastatic breast cancer and now as an adjuvant for women with early disease.^{3–4}

We now have the results of three large appropriately powered studies (and the interim results of a fourth) assessing the role of trastuzumab in addition to adjuvant chemotherapy for patients with HER2 positive tumours.^{5–7} The HERA (herceptin adjuvant) trial, with nearly 5100 patients, compared one and two

years of trastuzumab treatment with a control intervention in patients who had already completed their adjuvant chemotherapy.⁵ Two other trials were combined for analysis (National Surgical Adjuvant Breast and Bowel Project, B-31 and North Central Cancer Treatment Group trial, N9831).⁶ These trials differ from HERA in that patients were randomised before the start of chemotherapy and had the chance of being randomised to trastuzumab concurrently or sequentially to chemotherapy. Finally, BCIRG006 evaluated the use of two different chemotherapy regimens with or without concurrent trastuzumab.⁷

The most impressive finding from these trials is the enormity of the hazard ratios. In the combined trial of B-31 and N9831, the hazard ratio for breast cancer recurrence in the group receiving trastuzumab with chemotherapy, compared with chemotherapy alone, was 0.48 (95% confidence interval 0.39 to 0.59; $P < 0.0001$). In the HERA trial, the unadjusted hazard ratio for recurrence of breast cancer in the trastuzumab group, compared with the control group, was 0.54 (0.43 to 0.67; $P < 0.0001$ by the log-rank test, crossing the interim analysis boundary). The results were significant for all women regardless of age, hormone receptor status, tumour size, or number of positive lymph nodes. A major concern was the risk of cardiac toxicity associated with trastuzumab. The three year cumulative incidence of class III or IV congestive heart failure or death from cardiac causes in the trastuzumab