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Letter

"Polypill" to fight cardiovascular disease

Summary of rapid responses

EDITOR—There were some enthusiastic champions of the concept, but, overall, respondents remained to be convinced that the "Polypill" issue was indeed a collector's item and a possible contender for the most important *BMJ* paper in 50 years, as the editor had indicated.[1-5] Images of the tooth fairy and April foolery were invoked, along with gasps of horror, astonishment, and incredulity that the hypothesis should be taken for anything approaching rigorous science.

This was proof, if any were needed, that the *BMJ* had finally lost the plot, judged several contributors.

Chief among the concerns was the lack of trial evidence for the effectiveness of the Polypill, or any facsimile, for that matter. Wasn't the assumption that the six constituents would work cumulatively and in perfect synergy a foolish one to make on the basis of results from disparate trials? What about the effects of aspirin on people with asthma and allergies or the potentially serious side effects of each of the ingredients, some readers asked?

The merits of alternative combinations or additional ingredients were debated, and some inspired tongue in cheek varieties were suggested.

Some agreed that the hypothesis was at least worthy of testing, and others approved of the egalitarian stance of an all inclusive approach rather than simply targeting those most at risk. But many questioned the basis for the "spectacular claims." The 61% reduction in ischaemic heart disease using statins is around twice that of any statin trial to date, pointed out some respondents.

Others queried the absolute numbers needed to treat to obtain the population effects proposed by Wald and Law, especially in view of the well known difficulties of long term compliance with any drug. But some of those treating the elderly or diabetic patients suggested that all too often their patients were already taking drug cocktails, and that one combined dose would improve their quality of life and treatment compliance.

"Blunderbuss medicine," roared one reader, while milder responses said that mass prescribing ignores the differences in metabolism and blood rheology between younger and older people to say nothing of the racial and sex differences in responses to β blockers and angiotensin converting enzyme inhibitors.

Several considered the failure to include projected overall mortality data a major flaw in the hypothesis. Slashing rates of heart disease would simply increase the chances of dying from cancer, trauma, and brain disease, thought some. Others ventured that the data from the Framingham heart study on which the hypothesis is based were themselves flawed.

A widely held concern was the way in which a polypill might undermine personal responsibility for wellness and encourage unhealthy lifestyles. A sensible diet, exercise, and not smoking were the way to go; far from reducing the tendency to "medicalise" life, this "quick fix" would actually promote it. Others looked to the longevity of the Japanese, who manage perfectly well without the aid of a polypill.

Several contributors cautioned against the seductiveness of an attractive hypothesis, which might not automatically translate into benefit, citing hormone replacement therapy and beta carotene as examples. Others thought that the hypothesis was too good to be true and, as in the maxim, that probably meant it was.

But a few voices speculated that respondents had missed the point: the intention was to get people thinking, and as one contributor ventured: "This is not a panacea, but with minor changes it might be the face of secondary prevention to come."

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