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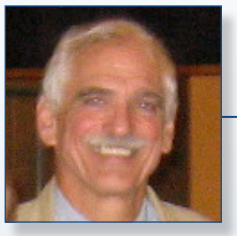



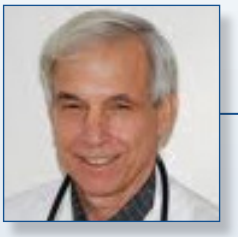



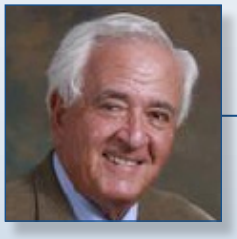



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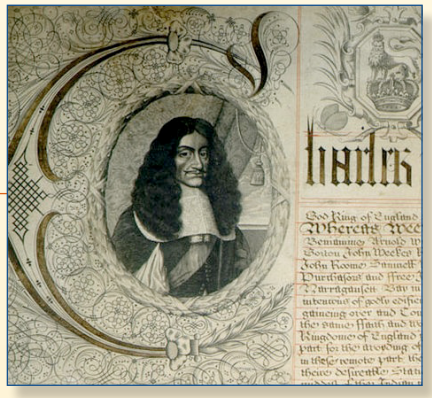

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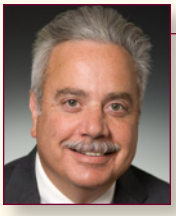
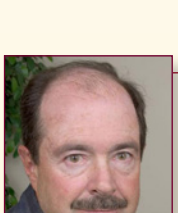
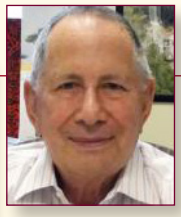


## PEOPLE







## IN THE NEWS









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# RHODE ISLAND MEDICAL JOURNAL



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## CONTRIBUTIONS



## PUBLIC HEALTH



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# What does it Mean for a Treatment to 'Work?'

JOSEPH H. FRIEDMAN, MD
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In medicine we understand, at least on a theoretical level, that our treatments often don't work. We like to think that they work more often than they do. We often assume that they're working a lot better than they are. Most patients join us in this last assumption. Patients often like to believe a treatment is working, and that often makes it work, and some patients don't like to disappoint the doctor so they say the treatment is working even when it isn't.

I suspect that most patients think that medications are usually intended to cure an illness. Infectious bacterial disease is the model. We treat an infectious disease until it is cured. If the infection isn't cured, we change the medicine. But many of our treatments aren't like that. Treating HIV, for example, isn't like that. We treat HIV by holding it in abeyance, keeping the virus contained. Anti-hypertensives lower blood pressure. They usually work sufficiently well but when they don't they can be adjusted until the treatment does, in fact, lower the recordings. The real payoff however, is not the blood pressure readings, it's the reduced risk of stroke, myocardial infarction and kidney failure, all of which are much increased in people with high blood pressure. Yet, these calamities may occur anyway, despite good blood pressure control and may even occur in people who never had high blood pressure. We treat to lower risk. When the treatment to lower one risk increases the risk of something else we have to decide which is more important.

We also have "symptomatic" treatment. In my field, movement disorders, we never cure anyone, we "manage" the condition by improving bothersome symptoms. How well a treatment works is in the eyes of the beholder. A patient may be disappointed, the doctor pleased, the family jubilant, or any combination of these. The most aggressive treatment for Parkinson's disease, deep brain stimulation, reserved for patients with very particular problems, often results in dramatic benefits. Paradoxically, successfully treated patients believe their improvement to be far less than assessments made by family and involved physicians. We sometimes have trouble deciding therefore if our treatment is successful. Controlling pain in someone whose pain etiology is untreatable is another form of symptomatic therapy. How can we judge when pain control is "adequate"?

Treating other conditions, like depression or anxiety, also involves symptomatic therapies, but, unlike Parkinson's disease, or chronic pain, depression and anxiety fluctuate, even untreated, making it impossible often to be sure the treatment had anything to do with the outcome. Further complicating our judgment is the natural history of depression, which is usually time-limited and resolves on its own. If one believes in evidenced-based medicine, we find that, unlike the scenarios in infectious diseases and Parkinson's disease, treatments for depression often don't work much better than placebo. This is not an exaggeration to make a point. If one uses the concept of "number needed to treat," that is, the number of people with a condition who need to be treated with a drug to make one of them "better" than if they were treated with a placebo, the usual numbers for depression are over four, meaning that four people need to be treated to make one better. Yet we don't tell patients this. Probably because we either don't know it ourselves, or we don't believe it. As with infectious diseases or Parkinson's disease, we treat with increasing doses or switch drugs, or say we treated it and ignore it.

I think we often use medications or other interventions because we believe they are likely to work. If we relied on evidence-based medicine too much we probably wouldn't use many treatments at all. After all, the evidence we rely on arises from studies that use tightly controlled entry requirements. Our confidence in a medication to reduce the risk of stroke may be predicated

on a study of patients who never had a stroke, or only those who had a transient ischemic attack (TIA), which may be a qualitatively different type of patient from the one in the office. In Parkinson's disease studies, we typically exclude people with cognitive dysfunction, so the effects of drugs on those with such problems are known only based on anecdotal evidence or open label trials, which are notably subject to bias.

However, the concept of the "number needed to treat" has always intrigued me. It would be easy, and likely will be coming to a health insurer in your neighborhood soon, for an insurer to argue that any treatment that "works" less than 25% of the time shouldn't be paid for, which would eliminate many psychotherapeutic drugs, and probably a lot of cancer drugs as well. Yet the other aspect has always been the large placebo effect. If you do nothing, nothing happens. If you give a sugar pill invested with a degree of confidence in improvement, the odds are much increased that benefit will occur. My guess is that when you give an active drug, not in a blinded fashion, as in a placebo-controlled study, but with the full authority of the medical establishment behind the medication's benefits, the chances of a drug working are undoubtedly much enhanced.

The number needed to treat should not be thought of in a defeatist manner, that you have to treat 3 or 4 or 5 people to make one better. Rather it should be used to maintain our humility in treating the many failures of the human body. ❖

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Joseph H. Friedman, MD, is Editor-in-chief of the *Rhode Island Medical Journal,* Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, and chief of Butler Hospital's Movement Disorders Program.

**Disclosures**

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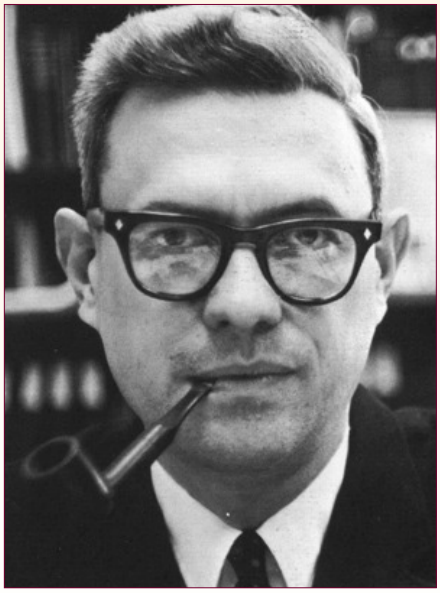
FROM RIMJ'S MANAGING EDITOR: For more information on The Aronson Chair, click here: http://www.butler.org/aronsonchaircampaign/index.cfm

BROWN

Dr. Aronson in 2007 receiving Doctor of Medical Science (DMS) at Brown in 2007.



DOWNSTATE

Stan Aronson, MD, in the early years in the 1950s at Downstate Medical Center in NYC.

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# Archy Strives for an Elusive Social Acceptance

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From its earliest days on the plains of Africa, mankind's survival has depended upon a vigilant awareness of his vulnerability and the use of every available resource in outwitting the many predators surrounding him. And so, in the absence of manmade weaponry, man ran faster, climbed trees more rapidly and exploited his brain in devising yet other survival strategies. Still, even without aggressive endowments such as claws, man managed to survive, prosper and spread to the other continents.

How did primitive humans manage to keep at bay the world of carnivorous creatures? Certainly humanity's survival demanded a ceaseless vigilance, the inventing of primitive weapons, working conjointly with other humans and devising protective structures such as rudimentary huts and defensible caves. The salvation of the genus *Homo* ultimately depended on guile, deception and superior intelligence.

Humankind has now conquered the world, effectively protecting themselves from the many harmful predators still wandering the diminishing forests, plains and seas. Yet, in the hearts of humans, there remains a lingering fear of these many feral creatures and an irrational need somehow to tame them.

Consider, for example, the lion: We hunt them as trophies; we capture them and then exhibit them in cages. And in our fiction we emasculate them, give them Swahili names such as Simba and imagine them as gentle humanoids with bushy manes.

The process of domesticating the entire animal kingdom has advanced so that we have now endowed many species with very human names such as Mickey, Donald, Bambi, even Dumbo (although citizens of Brooklyn have used the DUMBO acronym to signify "Down Under the Manhattan Bridge Overpass").

Are there no remaining creatures immune to taming through acculturation? Are there still creatures so vile, so nasty, so despicable that no amount of Disney-animation can diminish their malignant nature? Even the carnivorous dinosaurs, the feral vultures and the brooding bats have had their brief, animated interludes as allegedly harmless animals. Snakes, as yet, have not found willing advocates in the world of writers.

And finally there are the cockroaches, invertebrate creatures that have defied the remorseless inroads of Darwinian extinction and have persevered through the successive Paleozoic, Mesozoic and Devonian Extinction crises. Thousands of creatures, vertebrate and invertebrate, have been rendered extinct during those many apocalyptic intervals; yet the cockroach, little changed for hundreds of million years, has quietly survived.

The heightened survival capacity of the cockroach was best exhibited by an event during the final days of World War II. On the morning of August 6, 1945, an Air Force bomber identified as Enola Gay dropped an atomic bomb on the Japanese city of Hiroshima. The effects were immediately devastating and Japanese radio reported: "Practically all things, human and animal, were literally

The first illustration of Archy the poet reincarnated as a cockroach appeared in a New York newspaper, the Tribune, in 1922, introducing the new column by humorist Don Marquis.

seared to death." Except for the resident cockroaches.

The Atomic Bomb Casualty Commission (ABCC), established in 1948, commented frequently upon their apparent invulnerability to the intense radiation.

With such an indifference to the environmental hazards that befall other creatures, certainly there must be someone to proclaim the cockroach for its ability to survive these countless millennia. The journalist, Don Marquis (1878–1937) had written a tale, in 1927, of a cockroach named Archy, who had the astonishing ability to use a manual typewriter (yes, Virginia, there were such contrivances) in composing poems. And Archy's first effort read:

*expression is the need of my soul*
*i was once a vers libre bard*
*but I died and my soul went into the body of a cockroach*
*it has given me a new outlook on life*

Cockroaches, it must be emphasized, are far less dangerous than insects, which carry such ailments as malaria and bubonic plague. True, the cockroach is intensely unaesthetic, but they do have some biologic singularities: For example, they are capable of surviving without their heads for months, a unique trait share only by certain elected officials. ❖

**Author**

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### CONTRIBUTIONS

Contributions report on an issue of interest to clinicians in Rhode Island. Topics include original research, treatment options, literature reviews, collaborative studies and case reports.

Maximum length: 2000 words and 20 references.

PDFs or Jpegs (300 dpis) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text. Color images preferred.

### CREATIVE CLINICIAN

Clinicians are invited to describe cases that defy textbook analysis. Maximum length: 1200 words. Maximum number of references: 6.

PDFs or JPEGs (300 ppi) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text.

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The writer shares a perspective on any issue facing clinicians (eg, ethics, health care policy, patient issues, or personal perspectives). Maximum length: 600 words.

### ADVANCES IN PHARMACOLOGY

Authors discuss new treatments. Maximum length: 1000 words.

### ADVANCES IN LABORATORY MEDICINE

Authors discuss a new laboratory technique. Maximum length: 1000 words.

### IMAGES IN MEDICINE

Authors submit an interesting image or series of images (up to 4), with an explanation of no more than 400 words.

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