

Conflicts of Interest

TO THE EDITOR: In Part 1 of the Conflict of Interest series (May 7 issue),¹ Rosenbaum misrepresents the *New York Times* op-ed that we coauthored² and the referenced *BMJ* article that one of us coauthored³ as “emphasizing the frequency of [statin] side effects.” The primary focus of both pieces was that reanalysis of data from the Cholesterol Treatment Trialists (CTT) shows that statins do not provide a net health benefit to people with a 10-year risk of cardiovascular disease of less than 20%. This finding was challenged by Dr. Rory Collins (of the CTT), who called for retraction of the *BMJ* article. The external panel appointed to adjudicate this request relied on two independent statistical analyses and voted unanimously that the article did “not meet any of the criteria for retraction.”⁴ Whether the true incidence of statin-related side effects is 18% or 9% (as corrected) does not change the balance of benefit and harm. The panel added a final comment: the statin controversies cannot be resolved until the clinical trial data are available for independent assessment. The authors of the recent cholesterol guidelines did not have access to these data.⁵

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Dr. Abramson reports serving as an expert witness in litigation involving statins. No other potential conflict of interest relevant to this letter was reported.

1. Rosenbaum L. Reconnecting the dots — reinterpreting industry–physician relations. *N Engl J Med* 2015;372:1860-4.
2. Abramson JD, Redberg RF. Don't give more patients statins. *New York Times*. November 13, 2013 (http://www.nytimes.com/2013/11/14/opinion/dont-give-more-patients-statin.html?_r=0).
3. Abramson JD, Rosenberg HG, Jewell N, Wright JM. Should people at low risk of cardiovascular disease take a statin? *BMJ* 2013;347:f6123.
4. Heath I, Evans S, Furberg C, et al. Report of the independent panel considering the retraction of two articles in *The BMJ*. *BMJ* 2014;349:g5176.
5. Stone NJ, Robinson JG, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation* 2014;129:Suppl 2:S1-S45.

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TO THE EDITOR: In the third part of her series on conflicts of interest (May 21 issue),¹ Rosenbaum falsely states that the American Medical Student Association (AMSA) in its annual medical school scorecard (www.amsascorecard.org) “recommends prohibiting or actively discouraging faculty from giving industry-sponsored talks.”

The AMSA scorecard explicitly states on its website that “research relationships with industry may entail beneficial public presentations and speeches by individual researchers” and recommends that medical schools ensure only that a “talk is not promotional in nature, but purely educational” and that “industry has no role in determining or approving presentation content.” As of 2014, these recommendations have been adopted by 79 medical schools, including Harvard.

Lastly, AMSA has never sought “to help [medical schools] spread the anti-industry word.” The driving force behind AMSA campaigns has been to promote evidence-based rather than marketing-based prescribing practices and to enhance the relationship between physician-scientists and industry.

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Dr. Roper reports having served as chair of the PharmFree Campaign of the American Medical Student Association from 2008 to 2010. No other potential conflict of interest relevant to this letter was reported.

1. Rosenbaum L. Beyond moral outrage — weighing the tradeoffs of COI regulation. *N Engl J Med* 2015;372:2064-8.

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TO THE EDITOR: The series of essays by Rosenbaum¹ assert the importance of physician–industry collaboration on research and development of drugs and devices, but the outside role that industry plays in educating practicing physicians is mentioned only in passing. In our analysis of the Open Payments data,² after we excluded payments for research, royalties, and consulting fees, industry payments to physicians in the last 5 months of 2013 and during 2014 totaled approximately \$1.9 billion. This money paid for more than 400,000 lectures and close to 13 million drinks and meals. It may be true that we have yet to see strong data showing that industry influence nega-

tively affects patient outcomes, but it is troubling that we leave much of the continuing education of practicing physicians to an army of medically less-educated salespeople and to industry-sponsored lecturers delivering industry-written talks. If we are to accept that the development and trials of new drugs and devices necessitate collaboration with industry, with its attendant biases, then perhaps interpretation and education should be left to those without a dog in the fight.

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No potential conflict of interest relevant to this letter was reported.

1. Rosenbaum L. Understanding bias — the case for careful study. *N Engl J Med* 2015;372:1959-63.

2. Centers for Medicare and Medicaid Services. Open payments: dataset downloads. December 2014 (<http://www.cms.gov/OpenPayments/Explore-the-Data/Dataset-Downloads.html>).

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TO THE EDITOR: The three articles by Rosenbaum offered a truly fresh viewpoint on the increasing madness surrounding conflict-of-interest policies, and I applaud the *Journal* for publishing them. Rosenbaum's role as a whistle-blower can be compared with some examples found in the literature — *Catch-22* by Joseph Heller being a hilarious example.¹ In the novel, oath madness spearheaded by Captain Black reaches its peak when his “Glorious Loyalty Oath Crusade” forces combat pilots to spend their time in endless and spiraling concessions of pledging, even in the canteen before getting their lunch. The crusade finally comes to an end when Major ——— de Coverley, a mystic and authoritarian person, loudly orders, “Gimme eat.” Decent rules are needed, but too much is too much.

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Dr. Strandberg reports receiving lecture fees, consulting fees, meeting expenses, or research support from Abbott, Amgen, AstraZeneca, Bayer, Boehringer Ingelheim, Edwards Lifesciences, Novo Nordisk, Nutricia, Orion Pharma, Pfizer, and Servier and holding stock in Orion Pharma. No other potential conflict of interest relevant to this letter was reported.

1. Heller J. *Catch-22*. London: Vintage Books, 2011.

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THE AUTHOR REPLIES: Abramson and Redberg allege that my article misrepresented their *New York Times* commentary. That commentary, objecting to the cholesterol guidelines,¹ argued that statins provide no net health benefit to people with a 10-year risk of cardiovascular disease of less than 20%. One point of my series was that ideological agendas may bias people as much as financial conflicts do, though they are often subject to less scrutiny. In this instance, the authors, whose editorial was headlined “Don't Give More Patients Statins,” impugned the motives of the cholesterol-guidelines writers by suggesting that broadening of statin eligibility was motivated by profit incentives, despite the generic availability of most statins and unusually rigorous conflict management. For the public facing conflicting recommendations, the issue becomes one of credibility. It is thus relevant that Abramson and Redberg invoke financial conflicts to portray the guideline writers as untrustworthy, basing their own claims on an analysis Abramson coauthored that was found to have erroneously inflated the incidence of statin-related side effects.² For people considering statin therapy, falsely elevated side-effect rates undoubtedly affect perceived net benefit.

Roper says that it is false to state that AMSA recommends prohibiting or actively discouraging faculty from giving industry-sponsored talks. A review of the AMSA scorecard requirements, however, reveals that to receive the highest score, the policy at an academic medical center must effectively prevent “faculty from being paid by industry to do promotional speaking, or to be on industry-funded speakers' bureaus.”³ In addition, reviewing score trends in various domains, the AMSA website notes that “the most dramatic improvement is in policies regulating promotional speaking. 79 schools now effectively ban their faculty from serving on industry promotional speaker's bureaus, up from 44 in 2013.” Finally, though Roper says that the stated intent of AMSA is to enhance the relationship between physician-scientists and industry, the fact that an AMSA campaign and recommended curriculum was for several years titled “PharmFree” (now “Just Medicine”) seems antithetical to that collaborative spirit.

Fleischman and Newman point out the “outsize” role that industry plays in educating practicing physicians. One challenge remains separating intrusive, and at times misleading, marketing

practices from the industry collaborations needed to advance clinical care. The many types of interactions are often conflated, leading to a “pharma-is-evil” impression. The resultant aversion is warranted in some instances but in others enables a reflexive dismissal of sound science or expertise when generated by people whose industry collaborations seek to improve patients’ health.

Lisa Rosenbaum, M.D.

Since publication of her articles, the author reports no further potential conflict of interest.

1. Stone NJ, Robinson JG, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation* 2014;129:Suppl 2: S1-S45.
2. Abramson JD, Rosenberg HG, Jewell N, Wright JM. Should people at low risk of cardiovascular disease take a statin? *BMJ* 2013;347:f6123.
3. About the AMSA scorecard. Sterling, VA: American Medical Student Association (<http://www.amsascorecard.org/about>).

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Mesenteric Ischemia Mimicking ST-Segment Elevation Myocardial Infarction

TO THE EDITOR: A 61-year-old man presented to the emergency department with epigastric pain lasting 3 hours, preceded by vomiting and watery diarrhea for 2 days. He had a 7-year history of hypertension, diabetes mellitus, and dyslipidemia. At the time of presentation, his blood pressure was 77/53 mm Hg, his pulse rate 92 beats per minute, and his body temperature 35.5°C. On examination, his abdomen was flat and soft, without peritoneal signs. An electrocardiogram (ECG) showed Q waves with ST-segment elevation in the inferior leads (Fig. 1A). The provisional diagnosis was ST-segment elevation myocardial infarction (STEMI) of the inferior wall. Emergency coronary angiography revealed a 70% stenosis in the first diagonal branch of the left anterior descending coronary artery. The right coronary artery and left circumflex coronary artery were patent. Bedside echocardiography revealed preserved left-ventricular contractility without regional wall-motion abnormalities or apical ballooning.

A computed tomography (CT) scan of the abdomen showed pneumatosis intestinalis in the ascending and transverse portions of the colon. Gas was observed in multiple peripheral branches of the intrahepatic portal vein, as well as in the superior mesenteric vein and its tributary veins (Fig. S1 in the Supplementary Appendix, available with the full text of this letter at [NEJM.org](http://www.nejm.org)). An emergency exploratory laparotomy was per-

formed, and ischemic changes were observed in the terminal ileum and in the ascending and transverse colon (Fig. S2 in the Supplementary Appendix). A right hemicolectomy was performed, and the pathologist found diffusely denuded mucosa with villous blunting, membranelike exudate, transmural inflammation, edematous stroma, and serositis in samples from all sections of the ileum and colon; all these findings are compatible with ischemic colitis. An ECG obtained after surgery showed resolution of the ST-segment elevation (Fig. 1B). The levels of cardiac troponin T at presentation and at 3, 6, and 12 hours after presentation were 0.028, 0.017, 0.010, and 0.008 ng per milliliter, respectively (the 99th percentile upper reference limit in our laboratory is 0.014 ng per milliliter). The postoperative course was uneventful, and the patient was discharged 10 days later.

This case was a novel presentation of acute mesenteric ischemia mimicking inferior STEMI. The initial presentation of epigastric pain — which is a common symptom among patients with an acute inferior myocardial infarction¹ — along with ST elevation on the ECG led to a high suspicion of inferior STEMI that needed to be clarified immediately. Although a variety of conditions other than myocardial infarction may be characterized by ST-segment elevation,² we are unaware of any previous reports of acute mesenteric ischemia mimicking STEMI.