

less efficacious in patients with mild to moderate renal dysfunction, even in elderly people.³ New York Heart Association class, anticoagulation, and baseline heart failure drugs (including digoxin) were all adjusted for with Cox proportional hazard models, and we did sensitivity analyses in subgroups in the patients with atrial fibrillation. Models for all-cause mortality showed a consistent lack of prognostic benefit in patients with atrial fibrillation (overall hazard ratio 0.97, 95% CI 0.83–1.14) with no heterogeneity of treatment effect across studies ($I^2=0\%$, $p=0.65$).¹

The comments raised by Shah about other heart rate control drugs ignore the fact that no randomised studies of digoxin use in patients with atrial fibrillation have been done. Results from the largest study⁴ of digoxin versus placebo in patients with heart failure and sinus rhythm showed no difference in mortality compared with placebo overall, with a reduction in mortality at low digoxin doses and a significant reduction in hospital admissions.⁵ Whether these benefits will be present in patients with atrial fibrillation in a randomised trial⁶ has yet to be established. We emphasise that our study was a protocol-driven, preplanned analysis and not a post-hoc assessment.⁷ Additionally, the article⁸ referred to by Shah clearly distinguishes conventional subgroup analyses from those available with individual patient data: “Most subgroup analyses from systematic reviews are limited by between-study comparisons. The exception is IPD [individual patient data] meta-analyses in which most or all studies have included patients from each relevant subgroup. Investigators undertaking an IPD meta-analysis can conduct sophisticated analyses that compare the effects in subgroups within studies and then effectively pool across those studies.”⁸

Our data do not suggest a worse outcome with β blockers in patients

with heart failure, reduced ejection fraction, and concomitant atrial fibrillation, rather they challenge the clinical assumption that these drugs improve prognosis. Clinicians should therefore be able to choose therapy according to the individual needs of their patients. Further trial data specifically in patients with heart failure and atrial fibrillation are urgently needed and eagerly anticipated.

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Alcohol-related deaths: is misinformation hindering care improvement?

The UK Office for National Statistics states that “In 2013 there were 8416 alcohol-related deaths (ARD) registered in the UK...the age standardised death rate from alcohol-related causes was the lowest since 2000”.¹ Their definition of alcohol-related deaths includes only causes directly due to alcohol and does not include the many other diseases with which alcohol has a causal association (eg, cancers of the mouth, oesophagus, and liver, and road traffic and other accidents). This definition oversimplifies the detailed analysis in the recent *Lancet* Commission on liver disease,² and contrasts with the estimates of 49 000 alcohol-related deaths in France in 2009 (population 64.7 million in 2009 vs 63.7 million in UK in 2012), despite only a slightly higher adult per-capita consumption of pure alcohol in France (12 L in France vs 10 L in the UK) in 2010, which has plateaued in both countries since 2005.³

The European Action Plan to Reduce Harmful Use of Alcohol 2012–2020 includes monitoring and surveillance among its ten areas of action.⁴ Surprisingly, this report provides only coloured maps of mortality without raw data, and several countries did not provide any data at all.⁴

Why does alcohol control receive such little attention despite being responsible for one in seven deaths in men and one in 13 deaths in women and causing roughly 120 000 premature deaths in Europe? Most European countries do not have adequate policies because of a lack of political will and participation of the alcohol industry in the policy-making process.⁵ An effective response needs reliable comparable data as the platform for promotion of effective policy and care. Europe must provide



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For the European Cancer Observatory see <http://eco.iarc.fr>

corresponding resources as it does for cancer. The Seventh Framework Programme supported monitoring and surveillance of cancer (eg, ERA-NET and EUROCOURSE), and the International Agency for Research on Cancer developed a website (European Cancer Observatory) with the European Network of Cancer Registries.

Successive UK Governments have not followed the evidence and have protected vested trade interests.⁶ The UK Office for National Statistics is independent of government and reports to parliament, and should take a lead in provision of data that show the true scale of the problem, including the collateral damage of alcohol to third parties (eg, disabilities and death from accidents and violence—alcohol is the main factor in domestic violence). Until these data are provided, the government will continue to hide behind seemingly low numbers.

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The Middle East Cancer Consortium promotes palliative care

Cancer and other chronic diseases, is and will remain a major challenge for populations in the Middle East. Nowadays, about 50–60% of all patients with cancer in the region visit a physician for the first time when the tumour has reached stage 3 or 4, and is not curable.¹ The only therapy option left is palliation. Palliative care for patients with cancer is still a largely unknown and unrecognised discipline in most Middle Eastern countries.² Specific education for health professionals such as physicians, nurses, social workers, and psychologists will help them to develop palliative care services in their institutions and communities. The Middle East Cancer Consortium (MECC), established in 1996, is a unique and valuable non-governmental organisation that works in Middle Eastern countries and collaborates with regional Ministers of Health and international health-care organisations. MECC members, which include Egypt, Jordan, Palestine, Israel, Cyprus, Turkey, and the USA, and countries such as Pakistan, United Arab Emirates, Lebanon, Morocco, Iraq, Sudan, Qatar, and Oman, are actively participating in MECC's training programmes.

The MECC seeks to resolve the scarcity of palliative care in the Middle East by offering training and resources for oncology professionals. Through the development of palliative care programmes and improved communication between health-care givers and patients, palliative care might become more widely accepted in the region.³ Although the goal is to relieve the physical and psychological effects of cancer, analgesic and sedative drugs are often unaffordable in the Middle East. The average consumption of opioids in the eastern Mediterranean region in 2011 was

10.56 mg morphine equivalence compared with 61.66 mg worldwide.⁴

The Middle East has had many historical, social, and armed conflicts. The regional palliative care initiative serves as a basis for cooperative projects enhancing people-to-people engagements, including cross-border exchanges. These exchanges have focused not only on the maintenance of project activity but also strengthened personal relationships and mutual confidence between colleagues. Through this process, new opportunities for mitigation of enmity have developed. Hence, palliation has the potential to break down barriers of distrust between populations. One of the biggest hurdles to overcome is an absence of communication and understanding of cultural and religious differences between people in neighbouring countries.⁵ MECC trains oncology professionals to have more open and, ultimately, more successful discussions in the regions. These personal collaborations are not only about treatment schedules and drugs but also about understanding barriers and therefore building closer relationships than before. In 2015, MECC plans to organise the second Middle Eastern International Workshop on Integrative Oncology.

The continuing success of the regional palliative care programmes introduced by MECC suggests that despite many challenges, health initiatives in regions with conflicts can bring health professionals together. These cross-border collaborations can develop much needed new health-care services, with mutual respect, trust, understanding, and for the benefit of all involved.

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