The Hard Sell

Swamprat is intrigued by the current advertising campaign encouraging the middle-aged males of New Zealand to approach their GP and confess that they suffer from limpness of the vital organ. It is said that less than 2% of NZ males are willing to admit this particular weakness and the implication is that NZ GPs are pretty unwilling to raise the topic of the unraised organ in the course of their conversations with the consulting public.

Currently down here in the swamp we are having a great deal of difficulty dealing with the really pressing problems that people come up with like chest pain and asthma and broken limbs and it is sometimes really difficult to get around to questions about impotence. These usually come up at the end of a consult, and if I am feeling particularly PC, I relax back in my chair, assure him he is not the only person with the problem, that I have all the time in the world to compute his International Index of Erectile Function (IIEF) and invite the joker to tell me about what the problem might be and what we can prescribe for him. The evidence is that the advertised treatment works and is safe, but some of the observations in the evidence fascinate me.

The original study by Goldstein[1] (Irwin not Ira) et al, describes the comparison between Sildafenil (Viagra) and placebo in men with erectile difficulties. Placebo in this case is an interesting term as surely the participants would soon know whether they were on the real thing or not. They were given enough pills to see them through for a few weeks and asked not to try more than once a day. Interestingly enough there is no indication in the study that consent was obtained from their partners although each man had to be in a stable relationship with a female partner that had begun at least six months earlier. Of course there were no research assistants in the bedrooms making measurements so the study relied on assessment of efficacy using the responses to questions about frequency of penetration and maintenance of erections after penetration. The results showed that the active and placebo groups were significantly different ($p < 0.001$) but the mean scores for sexual desire were not significantly different in the two groups ($P = 0.13$). However we are told that those on Viagra made 5.9 attempts at sex per month compared to 1.5 on placebo. So if it was that good why did they not try more often? And if, as the advert on TV suggests, men are unwilling to admit their failures in the bedroom, how do we know they didn't make up the scores?

This is a column written from the swamp. The term is taken from the book by Donald Schon[1] where he talks about the crisis of confidence in professional knowledge thus:

In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solutions.

1. Schon DA. Educating the reflective practitioner. Jossey-Bass Publishers 1990.

Contributions

We invite amusing contributions to this column which should be relevant to the swamp and not more than 600 words.

The same statistical results arise when you look at the other big television ads which lead the patients to ask for the treatments they see on television. The $p<0.001$ evidence which leads the adverts to tout Orlistat as a way to lose weight comes up with an average weight loss over 28 weeks of about 3% over placebo.[2] Now for me that would be 3.6kg (big rats here in the swamp) for $160 a week or $1 244.44 per kg. Now this is significant but hardly world shattering. For the enormous people in the adverts it would hardly be a blip on the landscape. The other big advertiser is Flixotide which sends the punters in to get changed from Becotide. The problem the rat has is to decide whether to change them over. Well the evidence is that, if I do, the morning peak expiratory flow rate (PEFR) would improve from 382 litres/minute to 390 which is not even statistically significant.[3] Well this is better control! But by whom?

Direct to consumer advertising is certainly not a new phenomenon and I suspect it is only used when the evidence is extremely weak and when GPs can't be trusted to act wisely on behalf of their patients. When the rat was a Scottish ratling (my cover gets blown all the time!) my patients used to come in on Monday mornings with a cutting from the Sunday Post Doctor. Mandatory reading it was for the discerning GP. The headings were 'Marvellous new pills for Arthritis' and 'No need to suffer piles' or 'The diet that works!' It takes a lot of true humility to admit to your patients that there is something you don't know, and it was no trouble to change them from Brufen to Voltaren, Proctosedyl to Ultraproct or put them on the Scarsdale diet. The adverts are now evidence-based but the problem is that the evidence would never convict anyone. The people who respond to the adverts are a serious lot and they don't usually want a lecture on the pros and cons of spending their money in this way. They are usually bemused as to why they still have to come to the doctor to get the prescription. Don't worry, they'll soon be able to order them through Sky TV!

References

1. Goldstein I, Lue TF, Padma-Nathan H, Rosen RC, Steers WD, Wicker PA. Oral sildenafil in the treatment of erectile dysfunction. Sildenafil Study Group.N Engl J Med 1998 May 14; 338(20):1397–404.
2. Muls E, Kolanowski J, Scheen A, Van Gaal L. ObelHyx Study Group. The effects of orlistat on weight and on serum lipids in obese patients with hypercholesterolemia: a randomized, double-blind, placebo-controlled, multicentre study. Int J Obes Relat Metab Disord 2001; 25(11):1713–21.
3. Leblanc P, Mink S, Keistinen T, Saarelainen PA, Ringdal N, Payne SL. A comparison of fluticasone propionate 200 micrograms/day with beclomethasone dipropionate 400 micrograms/day in adult asthma. Allergy 1994 May; 49(5):380–5.