Reviewer’s report

Title: Do advertisements for antihypertensive drugs in Australia promote quality prescribing? A cross-sectional study

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Reviewer: Petra Denig

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The aim of this study was to determine whether print advertisements for antihypertensive medications promote prescribing for hypertension that is concordant with evidence-based guidelines. This question was answered by quantifying:

1. whether the key messages of such guidelines were addressed,
2. whether harms, prices, alternative drugs were mentioned,
3. which statistical claims were made.

Major Compulsory Revisions (which the author must respond to before a decision on publication can be reached)

The authors conclude that Australian antihypertensive advertisements largely do not promote quality prescribing. This is not sufficiently supported by the study as it is conducted/presented, and therefore both abstract and discussion should be adjusted on this point. The reason for this is that the authors appear to give more (subjective) attention/weight to some key messages (thiazide, lifestyle) than to others (range of drug treatments can be used, choice depends on patient characteristics). They give post-hoc reasons for why the advertisements were not promoting quality prescribing (not defined in their methods and not systematically evaluated).

From the method section, it is unclear how the findings were interpreted. The checklist is not provided, and I wonder whether only frequencies were extracted (yes/no) or whether additional information was systematically extracted (print size). Also, it is not clear whether any mention of specific messages/issues was to be interpreted as promoting quality prescribing. This information should be added. It seems that an additional (subjective?) weighing took place where the mention of harms/costs was downgraded because of the small print and the mention of subgroups was interpreted as possibly a negative aspect in the discussion.

The authors’ conclusion appears to be based on the finding that the assessed advertisements did not promote the key messages regarding lifestyle changes or thiazide mono-therapy as first-line treatment. However, key messages also include that the choice of antihypertensive drug may depend on characteristics of the patient, including other medical conditions or use of other
medications.’ 41% of the advertisements promoted their drug for a particular subgroup of patients. Unfortunately, the accuracy of this was not assessed but it could be that for these patients thiazide mono-therapy were not first-line treatment. To conclude that such advertisements did not promote quality prescribing seems inaccurate. Furthermore, in their discussion the authors make clear that only some guidelines promote thiazides as a uniquely preferable first-line choice in the absence of compelling indications. This nuance was not included in the key messages used for this study: Table 1 only states: A range of drug treatments exists (but not that many can be considered first-line choice).

Also, harms and costs were mentioned in most advertisements. Main outcome measure was defined as: mention of these issues. This implies that there was no predefined classification as to where/how this was mentioned. The finding that harms/costs were mentioned in 88/92% of the advertisements would support a conclusion that advertisements do promote quality prescribing. In comparison, in countries in Europe (where we have a similar Code) costs are seldom mentioned. Therefore, this finding is interesting to report.

Also, the high percentage of advertisements specifically reminding the reader to consider other than the advertised agents is very interesting (and surprising to me). But it is not clear whether this would be always positive, since the alternative promoted might be less evidence-based. Further assessment on its content is needed.

Finally, the authors refer to studies of 20 to 30 years ago to state that there is observational evidence of associations between doctors’ prescribing and doctors’ exposure to advertisements.[ref. 11-15] Given the changes in health care regulation and promotion of evidence-based medicine, it is relevant to refer to more recent studies. For example, in our group, Greving JP et al (Soc Sci Med 2006) showed that this influence of commercial information has not changed despite efforts of governments and professional organisations.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

I would like to have the checklist added to the manuscript.

Discretionary Revisions (which are recommendations for improvement but which the author can choose to ignore)

The authors were unaware of any other similar studies regarding messages in advertisements for antihypertensive medicines. Although a comparison to guidelines may indeed be innovative, comparisons have been made to determine whether print advertisements for antihypertensive drugs were evidence-based. This should at least be mentioned in the discussion. Again, in our group for instance, Greving JP et al conducted such an analysis for antihypertensive drugs (J Hypertension 2007).
What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.