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Calling tuberculosis a social disease—an excuse for complacency?

In the June 28 issue of *The Lancet*, Ali Mohsin re-discussed the paradigm of tuberculosis as a social disease.[1] The social element of tuberculosis is certainly important because there is strong evidence that tuberculosis does flourish in poverty, but this has several pitfalls. First, reservation of an exceptional social disease status for tuberculosis might, paradoxically, be detrimental, especially if the designation social suggests that poverty eradication is necessary to eliminate tuberculosis. Second, a paucity of studies show that social interventions have an effect on tuberculosis transmission and incidence.[2] Third, associating tuberculosis with poverty is a driver of stigma in communities.[3]

Is HIV any less social than tuberculosis? The HIV pandemic has taught us that with political will, adequate funding, community mobilisation, and scientific resources, the huge barriers of poverty and social deprivation can be overcome. On the contrary, given the dismal success of eliminating tuberculosis, perhaps the biomedical community has used the social paradigm as an excuse to underperform.

The emergence of drug-resistant tuberculosis is iatrogenic and suggests that the current biomedical and public health approaches for tuberculosis are failing. The time has come to use the successful HIV recipe (political will, money, activism, and brains) for tuberculosis. We have had enough of using the paradigms, diagnostics, and drugs of the previous century. We need a shift for tuberculosis: the one most important ingredient of a new paradigm is not biomedical or social, it is urgency.

We declare no competing interests.

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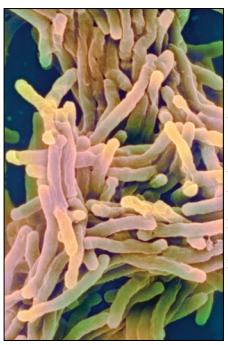
Cardiovascular outcome trials of glucose-lowering strategies in type 2 diabetes

We agree with Rury Holman and colleagues (June 07, p 2008)[1] that prospective cardiovascular outcome studies of glucose-lowering drugs cannot solve the problem of how to help patients and clinicians make decisions. We support the authors' proposal for exploitation of electronic health records to do large, low-cost, pragmatic randomised trials measuring real-world outcomes.[2] These trials should be the standard for all newly licensed drugs.

These trials, however, will permit assessment of only previously licensed drugs. We have published an analysis,[3] which suggests the need to rethink the criteria for approval, registration, and clinical use of new drugs. Even with optimistic assumptions, including cardiovascular benefit, we have estimated that more than 90% of people started on such treatment will not benefit. A 1% reduction in HbA_{1c} would add only about 10 months of quality-adjusted life for a 45 year old and 6 weeks for a 75 year old. But such gains would be completely eliminated by any treatment deemed, by the patient, to reduce the quality of life by more than 3%, a figure below that generally cited for injectable drugs. On this basis, even a drug for diabetes that improves cardiovascular outcomes might be a poor choice for many patients.

These measures of likely health gains matter because such treatments, although potentially providing benefit in aggregate outcomes, are being used for individual benefit. The patient should be the one who makes choices about treatment once they are fully informed of potential benefits, burdens, and harms. When these factors are closely balanced, and when patients vary in the weight they give to different factors, good quality information that is clearly communicated becomes particularly important. Data about glucose lowering falls far short of what licensing and regulatory bodies, clinicians, and patients need from new drugs for diabetes.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We declare no competing interests.

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