Credibility of Industry-Sponsored Clinical Research: Hype or Hope?

To the Editor: Will the 10 recommendations developed by the pharmaceutical industry and the publishing representatives close the credibility gap in reporting industry-sponsored clinical research? The guidance lacks targets and commitments. The recommendation on data disclosure does not even require companies to allow authors to have unrestricted access to all data. What’s the timeline for the guideline’s recommendations? What are the milestones? What are the concrete actions? Who will independently monitor the guidance implementation, which will require money and time?

Too many companies still exhibit poor records of ethics. GlaxoSmithKline recently agreed to pay $3 billion to settle civil and criminal investigations into its sales practices for numerous drugs, its fourth such case since April 2008, surpassing the previous record of $2.3 billion by Pfizer in 2009. In addition, Daniel W. Coyne just disclosed the saga of Amgen’s incomplete report on the early major trial of epoetin that misled the medical community about the anemia drug’s risks and benefits, which helped make Amgen rich. Should physicians be tempted to blindly accept general statements from recidivists?

The guidance promoted by Mansi et al is marked by a major conflict of interest. Publishers highly rely on publication of industry-supported trials, and thus these trials are associated with an increase in journal impact factors. Moreover, drug advertising and sales of reprints provide them with a substantial income.

Alain Braillon, MD, PhD
Amiens, France

5. http://dx.doi.org/10.1016/j.mayocp.2012.06.018

Commenting on Ten Recommendations for Closing the Credibility Gap in Reporting Industry-Sponsored Clinical Research

To the Editor: Anna Freud coined the term “identification with the aggressor” to describe how victims sometimes ally themselves with their tormentors. Reminiscent of such self-loathing behavior is a commentary published in the May issue of the Proceedings entitled “Ten Recommendations for Closing the Credibility Gap in Reporting Industry-Sponsored Clinical Research.” Employees of 5 major pharmaceutical industry publication departments and officials representing medical publishing professional trade organizations to which such employees belong joined medical journal editors in authoring the piece. They billed the exercise a “joint journal and pharmaceutical industry perspective.”

The commentary fails because, instead of assessing the evidence of whether industry-sponsored research is less credible than nonsponsored research, it engages in a public relations exercise to try to repair the tattered image that industry bashers have created. For example, to alter a perceived mismatch, allegedly “shared by many,” that industry-sponsored studies fail to meet the needs of the public and clinicians, the authors propose that “clinical studies and publications address clinically important questions.” The authors fail to provide a plausible explanation for how wasting resources on trivial questions is widely recognized as advantageous to industry or how a journal’s prestige is enhanced by publishing drivel. It urges greater “transparency” concerning protocol design, trial result presentation (including negative outcomes), and reporting of analysis methods, disclosure of authors’ ties to the research, elimination of “ghost-writing,” assurance that every listed author can defend the study designs, and improvement of authors’ writing and journal policy adherence skills.

However, the credibility gap or, even worse, the appearance of a credibility gap that the authors bid to close is based on their uncritical acceptance of industry-bashers’ signature framing bias, namely, that industry-sponsored publications are laced with conflicts of interest (actual or potential). Promoters of this bias, cited without rebuttal in the commentary, have failed to provide a quantitative dimension to the problems to be addressed by the commentary’s recommendations. Rather than acknowledge the real credibility gap between bona fide problems and the huge denominator of neutral or positive industry contributions to health care, they offer up unrepresentative “trouble stories” provided by politicians, unreliable media sources, and litigators. Some of the problems are speculative and stamped with the all-purpose conflict of interest epiteth. Others are at least debatable. Some are fabricated. Concerns about perceptions and appearances should be addressed by a fact-based inquiry to determine their validity, not by a desultory project vainly hoping to alter the perceptions of industry critics who continually perceive corruption.

For example, the commentary’s demand for “clinical importance” is a shallow indictment of so-called seeding trials, allegedly motivated by product marketing rather than science. However, all industry-sponsored trials ultimately have marketing in mind, and the trial outcome validity, not the trial motivation, is what matters for patient care. For journal editors, as they have done, to disavow peer-reviewed trials they have published when litigants claim the trials were commercially motivated is intellectually dishonest. In addition, the urban legend indictments of selective trial reporting ignoring timely publication of economically devastating results, evidence that industry-sponsored trials are predominantly of high quality and that most research misconduct has no industry or professional writer association.

Professional medical writers in and outside the medical products industry have an important role to play in the dis-
semination of information that advances patient care. However, they have been consistent victims of abuse by the conflict of interest mania that labels them as ghostwriters. In addition, in the vanguard of abusers have been medical journal editors with whom the professional writer victims allied themselves in the commentary. The writers should take a closer look at who they think their friends are.

An analysis of more than 100 articles in 4 medical journals concerning relationships among academics, physicians, and industry documented the aforementioned framing bias. Nearly 90% of the articles, contrary to empiric evidence, emphasized risks of relationships, and fewer than half of them provided any evidence to justify that emphasis. Two-thirds of those articles made conclusions about relationships on patient outcomes, which is what counts but for which no data were presented. Less than 15% even mentioned alternative hypotheses, such as whether seeding trials or ghostwriting are interpretable with the nuance they deserve rather than arbitrary black and white subjective certainty.

The corruption-hunting journal editors should look in the mirror, and the professional medical writers should run for cover. The editors’ actions are best explained by abuse of power as they strive to control and take credit for information provided by unsung researchers.

Finally, the commentary’s public relations campaign is a futile fool’s errand. For example, after heralding the first PhRMA Ethics Code, conflict of interest critics decried it to “a good start,” then derided it as inadequate and ultimately shredded it. The follow-on PhRMA Code acquiesced to what the critics supposedly wanted—no reminder items also known as gifts. The industry bashers simply ignored this fact and continue to pique about industry providing gifts to influence clinician decision making. Item makers are out of work, and the reminder-toting sales forces have decreased markedly, but the bashers have no evidence that any reduction in corruption was worth the trouble.

Lance K. Stell, PhD
Department of Philosophy
Davidson College
Davidson, NC

Surgical Excision of Invasive Aspergillosis of the Right Ventricle Presenting as Intractable Ventricular Arrhythmia and Right Ventricle Mass

To the Editor: Aspergillosis can manifest as either noninvasive (allergic disease or fungal ball) or invasive disease. The respiratory tract is the most commonly affected site, usually serving as the location of initial infection, often in immunocompromised hosts.1,2 Involvement of the heart is rare and, when present, typically manifests as infective endocarditis.1,2

The diagnosis of cardiac aspergillosis requires a high index of suspicion. Early diagnosis is imperative to ensure successful management, which involves complete resection and extensive surgical debridement to clear margins combined with antifungal medical treatment and lifelong suppressive therapy. We report a case in which complete surgical resection of a myocardial aspergilloma combined with long-term antifungal therapy resulted in excellent recovery.

A 52-year-old man with a clinical history of IgA deficiency, allergic bronchopulmonary aspergillosis, and bronchiectasis who was undergoing long-term corticosteroid therapy presented with shortness of breath, chest tightness, and paroxysmal palpitations. Recurrent, nonsustained ventricular tachycardia was documented, and cardiac imaging revealed a soft tissue mass, measuring 4.5 × 2.1 cm, on the anterior free wall of the right ventricle extending to the apex. Additional imaging revealed cystic bronchiectasis in both lungs and a probable aspergilloma in the upper lobe of the left lung (Figure 1). Catheterization with echocardiography-guided core needle myocardial biopsy was performed. Histologic sections of the biopsy specimen revealed granulomatous myocarditis. Rare septate branching hyphae were noted on silver stain, morphologically suggestive of Aspergillus species. Before cardiovascular surgery, intravenous lipid amphotericin B treatment had been initiated, but the patient developed...