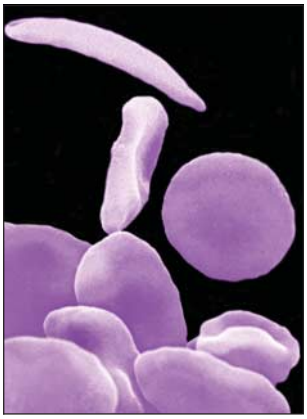
their performance, but only temporarily. Capacity constraints, long waiting times, and changes of managers were seen as preventing a sustained improvement.

All age groups benefit from new management of sickle cell disease

New treatments offer patients with sickle cell disease a prolonged lifespan and better quality of life. On p 1151 Claster and Vichinsky review recent advances and current treatment for these patients.



DR GOPAL MURTI/SPL

They emphasise the multidisciplinary approach, prevention of organ damage, and new treatments, such as hydroxyurea and drugs to increase fetal haemoglobin concentration.

POEM*

Aspirin protects women at risk of pre-eclampsia without causing bleeding

Question Does aspirin prevent pre-eclampsia and associated complications in high risk women?

Synopsis For this meta-analysis the authors sought high quality randomised controlled trials of low dose (by any definition) aspirin versus placebo for the prevention of pre-eclampsia and associated outcomes in women at high risk of pre-eclampsia by history. Risk factors were previous pre-eclampsia, chronic (pre-existing) hypertension, diabetes, renal disease, and extreme age at conception. Fourteen studies including 12 416 women met the inclusion criteria. Analysis for publication bias was somewhat limited because of the small number of included studies but indicated that publication bias was unlikely. The results were generally reported as weighted odds ratios. Results favoured aspirin therapy for diagnosis of pre-eclampsia (odds ratio 0.86; 95% confidence interval 0.76 to 0.96), prevention of perinatal death (0.79; 0.64 to 0.96), prevention of preterm birth (0.86; 0.79 to 0.94). Results were not different for bleeding complications (0.98; 0.79 to 1.21). Average birth weight was 215 (90 to 340) g heavier when mothers had had aspirin. Unfortunately, the methods used didn't include reporting of absolute risk differences, so we can't calculate number needed to treat. It is also not clear whether specific historical factors are associated with more or less benefit from aspirin.

Bottom line The literature published to date consistently shows a protective effect of low dose aspirin for women with risk factors for pre-eclampsia without an increase in bleeding complications, including placental abruption. The methods used did not permit absolute risk reduction and NNT to be determined.

Level of evidence 1a (see www.infopoems.com/resources/levels.html); systematic reviews (with homogeneity) of randomised controlled trials.

Coomarasamy A, Honest H, Papaioannou S, Gee H, Khan KS. Aspirin for prevention of preeclampsia in women with historical risk factors: a systematic review. *Obstet Gynecol* 2003;101:1319-32.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

Dawn of the diagnostic age

Have you often been bothered by feeling down, depressed, or hopeless? Have you often had little interest or pleasure in doing things? We might ask our patients—or even ourselves—these two questions, but how useful might they be in diagnosing depression? Doctors have been asking these and other questions for many years; even the shortest screening questionnaires generally run to at least seven questions and take several minutes in a consultation. Bruce Arroll and colleagues hypothesised that asking these two questions during a consultation would offer a quick and reliable screen for depression in primary care (p 1144). When both answers were no, people were unlikely to be depressed (high number of true negatives, low false negatives). But the method produced many false positives, requiring further questioning from the clinician to confirm the diagnosis. A weakness of the study is the lack of a non-screened comparison group, but the authors argue that their two questions are a "good compromise between the time required to administer the screen and the likelihood ratio."

More and more researchers are evaluating diagnostic tests. Paul Sullivan's team set out to determine how many common clinical tests used in a respiratory medicine outpatient clinic are based on high quality evidence (p 1136). Only half the tests used to make or exclude a diagnosis were supported by evidence of level 1a-1c. Only a fifth of tests that were used to assess a known condition were supported by high level evidence, and trials of therapy had no evidence to support them. Evidence based resources like the Cochrane database and *Clinical Evidence* have traditionally focused on therapeutics—but their focus is shifting to diagnostics. In the first issue of this year we published the STARD guidelines for reporting diagnostic studies. Clearly there is a raised consciousness about diagnostics, which Chris Del Mar and Paul Glasziou describe (p 1117) as "the dawn of a new phase of evidence based practice: the diagnostic age." Some of what we now take for granted, they say, will quickly become outdated as new ways appear, such as the two questions screening for depression as proposed by Arroll's team.

The diagnosis in the book that won the Man Booker prize this year, *Vernon God Little*, is clear: wrongful arrest. A young man's liberty is stolen by a system that has decided on his guilt instead of asking the right questions and performing appropriate investigations—a failure of detective work, you might call it. No such criticism can be made of syphilis detective Deborah Hayden, whose intuition leads her—in her book *Pox: Genius, Madness, and the Mysteries of Syphilis*—to "explosive conclusions" about how syphilis influenced the careers of Oscar Wilde, Vincent Van Gogh, James Joyce, and Adolf Hitler (p 1173) In another book, journalist Jörg Blech casts the medicalisation story in a German context after being enraged by a new psychiatric diagnosis for stressed fathers—"caged tiger syndrome" (p 1173).

Kamran Abbasi *deputy editor* (kabbasi@bmj.com)

To receive Editor's choice by email each week subscribe via our website: bmj.com/cgi/customalert