reports views of women consultants working in a London hospital. The discussions included topics such as stress at work, the importance of time management, role models and mentors, flexible training, full time employment, and academic careers.

POEM*

Reserve angiography and revascularisation for high risk patients with ongoing ischaemia

Question Is a routine or a selective invasive strategy more effective in treating acute coronary syndrome?

Synopsis Optimal treatment for patients with unstable angina or non-ST segment elevation myocardial infarction remains controversial. The investigators comprehensively searched Medline, the Cochrane Registry of Controlled Trials, abstracts from major cardiology meetings, and cross references from original articles and reviews for relevant trials comparing benefits and risks of routine versus selective invasive treatment strategies. A routine invasive strategy was defined as all patients with unstable angina or non-ST segment elevation myocardial infarction undergoing immediate coronary angiography, followed by revascularisation when appropriate. A selective invasive strategy was defined as all patients initially being treated pharmacologically, followed by angiography and revascularisation only for those with persistent symptoms or evidence of ongoing ischaemia. Only randomised trials with adequate concealment and follow-up were included in the review. Two researchers independently assessed the individual trials and extracted pertinent data. Of 84 articles identified initially, only seven (involving 9208 patients) met inclusion criteria. Follow-up occurred for a mean of 17 months. Mortality was significantly higher during the initial hospitalisation in the routine invasive strategy group (1.8% *v* 1.1% in the selective invasive strategy group), but after discharge the routine strategy was associated with a significantly lower mortality (3.8% *v* 4.9%). Overall, the composite outcome of death or recurrent myocardial infarction was lower in patients in the routine group than in the selective group (12.2% *v* 14.4%; number needed to treat = 45; 95% CI 28 to 119). Higher risk patients with raised cardiac biomarkers (for example, troponin and creatine kinase concentrations) at baseline benefited the most from the routine invasive strategy, but the routine strategy gave no benefit to patients with negative biomarkers. The outcomes of the various trials were somewhat heterogeneous, but the authors speculate that this is related to the concurrent use of other drugs in some, but not all, trials. Trials published after 1999 showed the most benefit from routine invasive strategy, suggesting a positive impact of improved treatment protocols.

Bottom line High risk patients with unstable angina or non-ST segment elevation myocardial infarction and positive cardiac biomarkers benefit from immediate coronary angiography and revascularisation, when appropriate. Similar patients with negative cardiac biomarkers seem to do as well with initial pharmacological treatment, so angiography and revascularisation should be reserved for patients with evidence of ongoing ischaemia.

Level of evidence 1a – (see www.infopoems.com/levels.html). Systematic review of randomised trials displaying worrisome heterogeneity.

Mehta SR, Cannon CP, Fox KA, et al. Routine vs selective invasive strategies in patients with acute coronary syndrome. A collaborative meta-analysis of randomized trials. *JAMA* 2005;293:2908-17.

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

Editor's choice

The kindness of strangers

On the fourth anniversary of 9/11, Americans find themselves once again counting the cost of an unimaginable catastrophe. This time though, the world has looked on not in awe at the human spirit arising from the ashes of the Twin Towers, but in shock and shame at the sight of the world's richest country doing so little so late for its poorest people. The fallout from Hurricane Katrina will be weighed in thousands of lives lost and many more thousands wrecked (pp 526, 531, 582), and in further damage to America's reputation around the world.

When the US government finally accepted offers of help from the United Nations last week, secretary general Kofi Annan might have been forgiven for feeling a certain degree of schadenfreude. This is after all also the UN's 60th anniversary, an opportunity for the UN's critics to crank up pressure to reform. Few would disagree that the UN is inefficient, bureaucratic, and encumbered with an impossibly broad mandate. In this week's *BMJ*, Kelly Lee calls it "a management consultant's worst nightmare" (p 525). But in the build up to next week's UN summit, US criticism of the UN—embodied in the form of US ambassador, John Bolton—has moved beyond these well worn gripes to questioning key aspects of the UN's strategy. Most significantly, Bolton has called for the removal from next week's agenda of all reference to the millennium development goals (MDGs).

Whatever one's view of the MDGs (seen by some as reflecting the priorities of donors rather than recipient nations and by most people as probably unachievable), they do focus attention in the rich world on the health needs of the poor. Targets give the international community a stick with which to beat itself when it falls short on commitments, as it is clearly doing (p 536).

The US government wants the world's attention to shift elsewhere, but the UN must resist this, whatever threats its largest donor makes to withdraw funding. America's own recent experience shows the dangers of diverting funds from routine public health initiatives to perceived, and probably overestimated, threats to homeland security. Erica Frank estimates that on 11 September 2001, and on every day since then, over 5000 people died in the US from 10 leading causes, including heart disease, cancer, and stroke (p 526). "Predictable tragedies happen every day," she says, but funds are being diverted to prevent bioterrorism, leaving health departments in the US without money for basic disease surveillance. The most recent effects of the diversions of funds can be seen in the disastrous flooding after Hurricane Katrina.

The neglected levees will be repaired, the flood waters will recede, and street cars will again ply their routes to New Orleans' sunken districts of Desire and Cemetery. But how much will America's leaders be willing to learn from their unfamiliar and uncomfortable experience of having had to depend on the kindness of strangers?

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