LETTERS

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CANNABIS REGULATION

Guidelines on cannabis use need to be developed

A regulated cannabis market could be a good thing.[1] Potential benefits range from breaking the dominance of drug cartels and redistributing law enforcement budgets to taxation, consumer choice, quality control, and reducing criminalisation of mostly young and otherwise law abiding citizens. But we mustn't end up with a net public health loss.

Any attempt at regulation must protect young people from early initiation into use and minimise the risk of a collateral increase in tobacco consumption. Cannabis is a gateway to tobacco use.[2] In most countries, more than 80% of cannabis smokers mix cannabis with tobacco[3]; this has synergistic health harms and makes it harder to quit.[4] A regulated market should encourage the production of cannabis with lower levels of tetrahydrocannabinol balanced by cannabidiol to reduce the frequency of unwanted effects, such as memory impairment and paranoia.

Governments will need to consider how to educate users about harms, support informed decisions around personal levels of consumption, and allow early detection of those at risk of problematic use. An appealing strategy is to develop guidelines similar to those for alcohol. However, in a 2013 global survey of more than 65 000 drinkers,[5] only 20% of participants who were aware of their country's alcohol guidelines paid attention to these guidelines.

We should learn from this finding and develop honest, acceptable guidelines around the mode of consumption and dose related nature of most cannabis related harms to create credible safer guidelines on use. One such example, based on the experience of 38 000 cannabis users, is the Global Drug Survey Highway Code.[3]

Finally, regulation will require serious post-marketing surveillance and the implementation of the smartest, most independent, public health policies that scientific lobbyist-free evidence can support. Now put that in your pipe and smoke it.

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Competing interests: I am founder and managing director of Global Drug Survey and developer of the cannabis drugs meter app (www.drugsmeter.com).

Full responses at: www.bmj.com/content/348/bmj.g3382/rr/699541 and www.bmj.com/content/348/bmj.g3382/rr/699819.

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ADVERSE EFFECTS OF STATINS

The BMJ statins papers misrepresent the facts

I fully support Rory Collins's request that *The BMJ* retracts Abramson and colleagues' and Malhotra's papers.[1-3] The authors totally misrepresent Zhang and colleagues' claims that statins were causally related to side effects in 20% of statin users.[4] The two papers also imply that these side effects were not reported in trials because trial sponsors could have influenced the results and downplayed the drugs' side effect profiles.

As co-chief investigator of ASCOT,[5] an independently designed and led trial, in which the data were analysed and published independently of the funder, Pfizer, I strongly refute such implications. In ASCOT, we detected drug related side effects of the angiotensin converting enzyme inhibitor (cough) and the calcium channel blocker (ankle oedema).[6] So if statins were causally related to myalgia or myopathy, why did we not detect this in a trial of 10 000 people?[7] Adverse events and withdrawals from treatment were identical in those taking placebo or statin. Perhaps the answer is provided by a recent study, where rechallenge of patients previously withdrawn from statin because of myalgia, yielded the return of identical symptoms with both statin and placebo.[8]

The effect of these papers[2 3] is that, for the wrong reasons, patients whose future morbidity and mortality from cardiovascular disease would have benefited substantially from statin therapy, will be dissuaded from taking the drugs or will discontinue them if they are already receiving treatment.

The BMJ has taken a strong position on scientific integrity, and its condemnation of the *Lancet*'s publication of the Wakefield measles, mumps, and rubella scandal was well received. The same principles should apply over the critical reviews of these two statin papers. The reporting of bad science is the prerogative of the lay press, not *The BMJ*.

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Full response at: www.bmj.com/content/348/bmj.g3306/rr/700606.

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PREVALENCE OF AUTISM

The proportion of true cases of autism is not changing

Blenner and Augustyn state that the Centers for Disease Control and Prevention (CDC) study design cannot answer the question of whether autism spectrum disorder is increasing.[1] We agree, but we do not agree with the implication that such evidence does not exist. Britain has an outstanding programme of epidemiological research which shows that the rate of autism in young adults is similar to that in older adults.[2] Unlike the CDC data, this evidence does not rely on services having identified or diagnosed autism. Instead, it is based on a large, national, community based survey of the adult English population, which uses consistent methods of autism assessment.

Our findings suggest that the recognition of autism in children is probably rising, but that the proportion of true cases is not changing. At the very least, the title of the editorial should be "Are diagnoses of autism in children rising…?" Why is this important? Concern for a rising epidemic of autism is misguided. Rather, there should be major concern about the substantial number of adults who struggle with autism, who lack the comfort and support that recognition and perhaps understanding and acceptance could bring.

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HAEMOGLOBIN A_{1C} AND TYPE 2 DIABETES

HbA_{1c} :reliable test for type 2 diabetes in primary care

Chronic kidney disease (CKD) is relatively common and has been reported to affect glycated haemoglobin (HbA_{1c}).[1 2] Kilpatrick and Atkins advise against using HbA_{1c} to diagnose type 2 diabetes in end stage renal failure (CKD stage 5),[3] consistent with a previous report.[4] There are, however, no data on the effect of lower stage CKD on HbA_{1c}.

We recently evaluated the diagnostic use of HbA_{1c} on 949 consecutive patients in primary care.[5] Of these, 83.7% had a normal estimated glomerular filtration rate (eGFR) of ≥60 mL/min/1.73m^2 (CKD <3), 16.3% had a rate of 30-59 mL/min/1.73m^2 (CKD 3). Only two patients had an eGFR <30 mL/min/1.73m^2 (CKD ≥4). Compared with patients with a normal eGFR, those with CKD stage 3 had higher HbA_{1c} concentrations (P<0.001). After adjustment, however, for age, ethnicity, sex, and haemoglobin, HbA_{1c} was not associated with CKD stage.[5]

Type 2 diabetes is largely diagnosed and managed in primary care. Our data indicate that HbA_{1c} is a suitable diagnostic test for this condition in primary care irrespective of CKD, because CKD stage <4 does not affect HbA_{1c} and higher stage CKD is rarely encountered.

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Competing interests: None declared.

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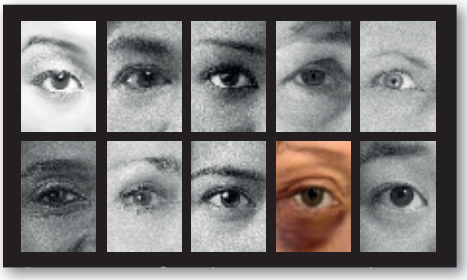
INTIMATE PARTNER VIOLENCE

Intimate partner violence affects men as well as women

O'Doherty and colleagues' meta-analysis of the effectiveness of screening women for intimate partner violence highlights the sex bias in the reporting of, and research into, this subject.[1] Domestic violence is widely presented as, and perceived to be, a women's health problem, and the authors make no reference to men who are victims of such violence.

The most reliable estimate of the extent of domestic violence in England and Wales



indicates that men experience 40% of all domestic violence (800 000 assaults on men in 2013 *v* 1.2 million on women).[2] The number of assaults on men is probably an underestimate because of the reluctance of these men to seek help,[3] partly because of the taboo nature of violence against men, and the fear of being rejected, humiliated, or ridiculed by professionals.[4] Even when these men do contact the police, violent women are more likely than violent men to avoid arrest,[5] and violent women are often viewed by law enforcement officials and the criminal justice system as victims, rather than as the perpetrators of violence against men.[6] Support services for men who are victims of domestic violence are lacking, and healthcare professionals often don't have the appropriate training to deal with and support these men.[5]

Intimate partner violence is a serious public health problem that affects men as well as women. Public discussions about domestic violence that systematically privilege the experience of women, while ignoring that of men, collude with cultural norms that view the suffering of women as more important and more serious than that of men. This type of misandry obscures the equivalence of all human suffering, irrespective of the sex of the victim.

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