Editor's comment

Incidentalomas

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The *British Medical Journal* is currently running a series of articles in the 'Too much medicine' series, and recently one in particular caught my eye. Called 'Too much medicine; too little care',[1] the editorial starts with a quote from Margaret McCartney: 'Too much testing of well people and not enough care for the sick worsens health inequalities and drains professionalism, harming both those who need treatment and those who don't'.[2]

Authors Glasziou, Moynihan and Godlee[1] lament the fact that the definitions of common conditions such as diabetes and kidney disease have expanded to the extent that larger and larger numbers of people are being labelled as 'ill'. In the meantime, practitioners' time for managing the most worryingly ill, disturbed and vulnerable has shrunk. This applies to definitions of mental and physical disorders.

There is an increasing realisation that it may be necessary to change the way that information is given to patients, e.g. are all lesions detected by the screening of 'cancers'? I have already discussed screening for breast cancer at length – and the literature on the harms of breast cancer screening mentions other cancer screening programmes that may also cause harm. Recently, investigators have detected a tripling of the incidence of thyroid cancer in the USA, Australia and elsewhere between 1975 and 2012,[3,4] with no change in the death rate. This suggests that this rise in incidence is a consequence of increased screening and improved diagnostic tools rather than a real change in the incidence of thyroid cancer.

However, Glasziou *et al.* highlight a possibly more important expansion in illness, where disease definitions have changed to the extent that the dividing line between normal and abnormal has narrowed – as has occurred with hypertension, diabetes, osteoporosis, high cholesterol, obesity and cognitive impairment. These small changes have massively increased the numbers of people labelled with a particular disease – in some cases, nearly all of them. And, of course, there has also been the inclusion of a huge proportion of the population being 'pre-hypertensive, pre-diabetic', etc. This is good news for the pharmaceutical companies, but bad news for individuals, healthcare systems and populations in general.

Although there are some who will benefit from early diagnosis and treatment, many will suffer the adverse effects of treatment that may not be necessary, to say nothing of the anxiety and stigma of being labelled with a disease – and cancer is probably the worst of those, particularly with the increased usage of the term 'cancer survivor'.

The *BMJ* is now running a series of intermittent articles looking at the risks and harms of overdiagnosis in a broad range of common conditions – the first of which is an article that suggests that the introduction of computed tomography pulmonary angiography led to an associated 80% rise in the detection of pulmonary emboli – many of which, the authors argue, do not need to be found.[5]

So what are the signs of overdiagnosis? Some 'red flags' suggested by Glasziou *et al.* are an increasing incidence while mortality stays the same, labelling a risk factor or biomarker to sound like a disease [a favourite of the pharmaceutical companies – Editor's note], and a shift in diagnostic definitions or thresholds with no clear evidence that benefits are greater than harms. They also raise some questions: Is this a risk factor or a symptomatic condition? Do the 'labels' reflect that distinction? Who has set the thresholds, based on what evidence of benefits and harms? Does this new test detect more and earlier 'disease'? Do we understand the natural course of the disease in those extra cases?

1. Glasziou P, Moynihan R, Godlee F. Too much medicine; too little care. BMJ 2013;347:f4247. [http://dx.doi.org/10.1136/bmj.f4247]
2. McCartney M. The Patient Paradox: Why Sexed Up Medicine is Bad for Your Health. London, UK: Pinter and Martin, 2012.
3. Davies L, Welch HG. Increasing incidence of thyroid cancer in the United States, 1973-2002. JAMA 2006;295:2164-2167. [http://dx.doi.org/10.1007/s10552-009-9459-z]
4. Australian Institute of Health and Welfare. Cancer Survival and Prevalence in Australia: Period Estimates from 1982 to 2010. Canberra: Australian Institute of Health and Welfare, 2012. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422721 (accessed 3 September 2013).
5. Weiner RS, Schwartz L, Wooloshin S. When a test is too good: How CT pulmonary angiograms find pulmonary emboli that do not need to be found. BMJ 2013;347:f3368. [http://dx.doi.org/10.1136/bmj.f3368]

CME is published monthly by the South African Medical Association
Health and Medical Publishing Group,
Private Bag X1, Pinelands, 7430 (Incorporated Association not for gain. Reg. No. 05/00136/08).
Tel. (021) 681-7200 E-mail: publishing@hmpg.co.za
Head Office: PO Box 74789, Lynnwood Ridge, 0040. Tel. (012) 481-2000
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