ommended using HPV testing because it would lead to fewer visits to the primary care provider. We further reasoned that with less than three years since first vaginal intercourse it would be highly unlikely that an HPV infection once established would have led to a high grade lesion.

There are no Canadian guidelines yet that appropriately take into account HPV testing. The Pan-Canadian Forum on Cervical Cancer Prevention and Control[3] has provided a fast-track opportunity to generate such evidence in the context of our country's screening programmes. In the meantime, however, we believe that the algorithms we proposed are a scientifically and clinically cogent management option.

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DOI:10.1503/cmaj.1060030

Not all guidelines are created equal

I have read with interest the recent editorial criticizing the Canadian Diabetes Association (CDA) Clinical Practice Guidelines (CPGs).[1] I am one of the few physicians who have served on both clinical practice guideline groups and drug review panels (in my case the CDA and Canadian Hypertension Education Program [CHEP] guideline groups and the Ontario Drug Programs Branch Pharmacoeconomic Review Committee respectively). The mandate of guideline groups and drug review panels differ so extensively that one should expect that their respective conclusions will often differ. Guideline groups advocate use of the most effective therapies as suggested by the medical literature, and typically do not perform economic analyses when generating guidelines. Drug review panels determine whether a new therapeutic is sufficiently cost-effective and has an acceptable budget impact within the context of their jurisdiction. There are 4 primary reasons why guideline groups do not (and in my opinion should not) perform economic analyses when generating guidelines. First, guideline groups do not have a mandate from any provincial or federal agency to make decisions about what therapies will be publicly funded. Equally important, they have no mandate to recommend removal of currently funded therapeutics when the cost-effectiveness of care would benefit from such an action. Second, guideline groups are not provided projected budget information that would help inform an economic assessment. Third, one could consider an assessment of effectiveness to be somewhat "universal." In contrast, the determination of whether a therapy is acceptably cost-effective can certainly vary between jurisdictions. Finally, an economics based approach would place guideline groups in a true conflict of interest between their patient advocacy role and their obligations to the health care payors. It is important to recognize that the quality of the health economics section of a company's approval application could be lower than the clinical section, which could affect the subsequent conclusions about the drug.

The roles of guideline groups and drug review panels are both necessary and complimentary. Recognizing that the most effective therapies will not always be the most cost-effective leads to the appropriate expectation that guideline groups and drug review panels may reach opposite conclusions. The potential for dualities of interest is real, and guideline groups have processes in place to allow for declarations of potential conflicts. Making these declarations accessible to reviewers is a reasonable request. I would also suggest that making available the guideline's technical documents would be helpful in explaining how a literature review led to a specific guideline, and would mitigate criticism that self-interest motivated particular recommendations. CPGs are an essential resource for clinicians. Allowing reviewers to be aware of potential conflicts of interest is reasonable. Excluding publication of guidelines because potential conflicts of interest may exist is not.

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Competing interests: Dr. McFarlane has been involved in continuing medical education events and/or advisory boards that have been sponsored by companies that sell insulins in their product lines, including Sanofi-Aventis, the maker of insulin glargine.

DOI:10.1503/cmaj.1050268

A recent *CMAJ* editorial drew attention to the potential for conflicts of interest to influence the development of clinical guidelines.[1] While we share your concerns, we wanted to register our disagreement with the *CMAJ* editorialist's conclusion that the only way to reduce potential conflicts of interest is to mandate that guideline panels consist only of non-experts. We believe strongly that clinical expertise in a particular area is necessary to properly interpret evidence related to that area.

We believe that the best solution to the dilemma raised by your editorialist is to ensure that guideline panels develop a transparent system of checks and balances that ensures both the integrity of the process and the quality of the recommendations made. To that end, we would like to point out that the hypertension recommendations produced by the CHEP are developed annually by experts from a variety of disciplines, none of whom are paid for their CHEP activities, and the following steps are taken to minimize potential biases:

1. An independent steering committee (consisting of representatives of the