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LETTERS

WHATEVER HAPPENED TO THE POLYPILL?

Polypill is not just for cardiovascular disease

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Viera's article on the polypill focused exclusively on cardiovascular benefits.[1] Yet several candidates for inclusion in such a formulation, such as aspirin and metformin, have shown anticancer activity in recent years.

Randomised trials show that aspirin prevents the development of colorectal cancer,[2 3] and long term follow-up from vascular trials indicates that aspirin inhibits development of metastases in a range of cancers.[4] This latter hypothesis is being evaluated in several randomised trials,[5] and metformin is being evaluated as a treatment for both breast and prostate cancer.

In 2015, the US Preventive Services Task Force judged the evidence sufficient to recommend daily low dose aspirin for primary prevention of cardiovascular disease and colorectal cancer in people aged 50-59 with a moderate risk of cardiovascular disease and no increased risk of bleeding.[6] This approach factors in potential benefits (cardiovascular and cancer outcomes), as well as age, which is associated with bleeding risk.

Although aspirin increases bleeding risk, events are rarer than generally appreciated: an estimated 3.6 additional serious extracranial bleeding events (fatal or requiring transfusion) per 10 000 people treated for a year with aspirin. Intracranial haemorrhage is rarer still (0.8 additional events).[7]

Instead of asking what happened to the polypill, perhaps we should be asking how we can update our thinking about the polypill. We agree that more evidence, including from the trials mentioned, is needed before aspirin or a polypill containing aspirin is recommended more widely. Evidence of anticancer effects may shift the risk-benefit balance for some people. A more individualised approach that assesses all possible benefits, as well as risks, is likely to be appropriate and might help the idea to slowly but surely gain ground.

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Full response at: http://www.bmj.com/content/356/bmj.j1474/rr-1.

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