Comparison of Meeting Abstracts and Subsequent Articles

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translate into net good accomplished. I do not argue that we should never donate vitamins—I argue that all medical care carries with it the responsibility to provide long-term accountability. It matters less what you pack in your duffle bag than how you unload it.

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Comparison of Meeting Abstracts and Subsequent Articles

To the Editor: In their study evaluating the degree of consistency between meeting abstract and subsequent full-length journal article, Dr Toma and colleagues[1] found discrepancies between the efficacy estimate for the primary outcome in 60 (41%) of the 148 randomized controlled trials. This highlights the need for scrutiny of the quality of information from randomized controlled trials.

There is another often neglected issue: the percentage of patients meeting inclusion criteria who actually entered randomization.[2] This important index tells a lot about the design and conduct of randomized controlled trials. While it is rare for all eligible patients to be willing to participate in a randomized trial, if the percentage is too low it raises questions about why so many patients would decline to join. Did they or their physicians feel the risk-benefit ratio of joining this trial was unfavorable? Were only those who were most likely to benefit from the new treatment invited to participate? If so, what were the real inclusion criteria? Perhaps the lack of logistic support was the true reason for selective enrollment.

Both the number of eligible patients and the number of patients who actually entered randomization are part of the required information for the CONSORT E-Flowchart.[3] Unfortunately, many authors do not report this information in their articles; it is not clear why some authors provide this information and other do not.

Mandatory reporting of the percentage of eligible patients who actually entered randomization of phase 3 and later-stage clinical trials would create an incentive for better design of clinical trial protocols, better specification of inclusion criteria, and better logistic operations. Perhaps the International Committee of Medical Journal Editors[4,5] should consider this for future articles reporting the results of randomized controlled trials.

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1. Toma M, McAlister FA, Bialy L, et al. Transition from meeting abstract to full-length journal article for randomized controlled trials. *JAMA*. 2006;295:1281-1287.
2. Fielding LP, Grace R, Hittinger R. Patients who are eligible but not randomised should be included as additional comparative arm in study. *BMJ*. 1999;318:874-875.
3. The CONSORT E-Flowchart. The Consort Statement Web site. http://www.consort-statement.org/Downloads/download.htm. Accessed February 15, 2006.
4. Rennie D. Trial registration: a great idea switches from ignored to irresistible. *JAMA*. 2004;292:1359-1362.
5. DeAngelis CD, Drazen JM, Frizelle FA, et al. Clinical trial registration: a statement from the International Committee of Medical Journal Editors. *JAMA*. 2004; 292:1363-1364.

This letter was shown to Dr McAlister, who declined to reply on behalf of the authors.—ED.

Unreported Financial Disclosures in a Study of Migraine and Cardiovascular Disease

To the Editor: In the July 19, 2006, issue of *JAMA*, we evaluated the association between history of migraine and risk of cardiovascular disease in women.[1] While we believe that we have no financial interests, relationships, or affiliations that would be relevant to our describing a biological link between migraine and cardiovascular disease, in response to the Editor in Chief and in light of the most recent *JAMA* disclosure guidelines,[2] we are disclosing all nonfederal relationships of every coauthor.

Dr Kurth has received investigator-initiated research grants from Bayer AG, McNeil Consumer & Specialty Pharmaceuticals, and Wyeth Consumer Healthcare; he is a consultant to i3 Drug Safety and has received an honorarium for contribution to an advisory board from Organon.

Dr Gaziano has received investigator-initiated research grants from BASF, DSM Pharmaceuticals, Wyeth Pharmaceuticals, McNeil Consumer Products, and Pliva; has received honoraria from Bayer and Pfizer for speaking engagements; and is a consultant for Bayer, McNeil Consumer Products, Wyeth Pharmaceuticals, Merck, Nutraquest, and GlaxoSmithKline.

Dr Cook has received research support from Roche Molecular Systems and has served as a consultant to Bayer.

Dr Logroscino has received honoraria for lectures from Pfizer and Lilly Pharmaceutical.

Dr Diener has received research support from Allergan, Almirall, AstraZeneca, Bayer, GlaxoSmithKline, Janssen-Cilag, and Pfizer; he has received honoraria for participation in clinical trials, contribution to advisory boards, or oral presentations from Allergan, Almirall, AstraZeneca, Bayer Vital, Berlin Chemie, Böhringer Ingelheim, Bristol-Myers Squibb, GlaxoSmithKline, Grünenthal, Janssen-Cilag, Lilly, La Roche, 3M Medica, Merck Sharp & Dohme, Novartis, Johnson & Johnson, Pierre Fabre, Pfizer, Schaper & Brümmer, Sanofi-Aventis, and Weber & Weber.

Dr Buring has received an investigator-initiated grant from Dow Corning Corp; has received research support for pills