

meeting held each year in December, where we produce a collection of reviews from selected speakers, entitled *BJA/PGA*.

Our publishers, OUP, are currently moving all of their journals to a new Highwire platform, which will present the journal content in a more attractive fashion. Coupled with this, we are setting up an increased online presence for supplements and will also create online bundles of articles around specific topics, called 'microsites'. *BJA* will move onto this new platform in early 2015.

These changes will have ramifications for both *BJA* and *CEACCP*, and it is most likely to be with *CEACCP* that we will first see the changes. The Board recognize that this journal is greatly appreciated, and we wish to rebrand and expand its remit. In recognition of the close links with the *BJA*, we have proposed that *CEACCP* changes its name to *BJA Education* to provide a better indication of the role we would like it to have. The Editorial Board agreed to this change at its last meeting. Over the coming months, it will start to have expanded content (podcasts, journal club, blogs and the ability to explore new ideas easily), all available only to online readers. This will clearly take time to establish, and we would actively encourage the submission of articles and other material that help us to fulfil this expanded role. Hopefully, readers will also start to appreciate the benefits of online access to *BJA* itself.

The Board and I would not wish to force this change on its readers, but we hope that the advantages of electronic access will become so apparent that readers will increasingly demand the switch from paper to online access. Both *BJA* and *CEACCP* can already be accessed online. Please try going to the *BJA* home page (BJA.oxfordjournals.org/) and sample what is available. To access journal content easily, it is convenient to have an email sent to you when each new issue becomes available; this is called the eTOC alerting system. Within the email are the tables of contents (TOC) along with hyperlinks to open individual articles directly, again both for *BJA* and *CEACCP*. To access this service, go to the *BJA* homepage and on the right-hand side can be found an alerting service button. Click either *BJA* or *CEACCP* or both for email alerts for the table of contents and also access to advance publication. You may also need to access the 'My accounts' page and sign in with your credentials or if you have forgotten them then click the relevant hyperlink. You can find your subscriber number on the mailing sheet enclosed with your copy of the journal.

I would hope that these changes will be welcomed by most readers once they have had chance to sample the extra material which will be available. But it is important for us to maintain a dialogue with our readers, and we welcome feedback to ensure we are on the right track; letters to the editor in electronic format would be welcome.

British Journal of Anaesthesia 114 (1): 2–3 (2015)
Advance Access publication 7 August 2014 · doi:10.1093/bja/aeu262

Consensus statement from the *BJA* Workshop on Cancer and Anaesthesia

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Over the course of a 2 day expert workshop held on the topic of cancer and anaesthesia at the College of Anaesthetists of Ireland in Dublin, Ireland, the following consensus statement was developed by delegates to this unique *BJA* workshop (see *online BJA open access supplement July 2014*). This followed from their presentations of their own ongoing cutting edge research in this area and intensive interactive discussions around the existing literature and the priorities for future research. Initial brainstorming sessions resulted in a list of statements under various categories that was progressively distilled to the following concise summary after extensive inclusive discussion. We urge national and international research funding bodies to take note of these recommendations, particularly in terms of funding large-scale prospective, randomized, blinded clinical trials that can most effectively address the important clinical questions raised. We also urge the anaesthesia and cancer research communities to comment by corresponding with the *BJA* through its eLetter mechanism (<http://bj.oxfordjournals.org/letters/>).

- (i) While the concept that anaesthetic or analgesic technique might affect cancer outcomes is intriguing, there is currently insufficient evidence to support any change in clinical practice.
- (ii) Available data on the role of opioids in cancer are conflicting, possibly due to the use of different experimental models. Long-term opioid administration in subanalgesic doses in mice without surgery suggests that morphine promotes cancer growth. In contrast, mouse models resembling the perioperative setting, using analgesic doses of opioid, suggest either a protective effect of opioids for cancer or no effect.
- (iii) Morphine does not appear to stimulate tumour initiation, and there is currently no evidence that morphine analgesia causes cancer. Whether opioid administration augments the risk of recurrence or metastasis after cancer surgery remains unclear. Currently, available research data are insufficient to indicate a change of clinical practice.
- (iv) Collaboration should be sought with other specialists (medical and surgical oncologists, cancer immunologists) and existing clinical oncology registries (e.g. European Organisation for Research and Treatment of Cancer) in an attempt to study the link between anaesthetic technique(s) and cancer outcomes in surgical oncology patients.
- (v) Based on recent experimental research, the expert group calls for randomized clinical trials to evaluate the effect of adjunct medications used during anaesthesia for primary cancer surgery on cancer recurrence or metastasis. Specific recommendation for further evaluation includes the effects of regional anaesthesia and analgesia, i.v. lidocaine, and non-steroidal anti-inflammatory drugs on cancer recurrence and metastasis.

Declaration of interest

D.J.B., D.M., and H.C.H. are members of the Editorial Board and H.C.H. is one of the editors of the *BJA*. G.S. is a member of the Associate Board of the *BJA*. M.W.H. is the section editor of *Anesthesia and Analgesia*.

British Journal of Anaesthesia 114 (1): 3–5 (2015)

Advance Access publication 5 September 2014 · doi:10.1093/bja/aeu263

Power of negative thinking

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Medical research adds value when it is associated with a meaningful reduction in uncertainty, and especially when it has relevance to clinical practice and to society.¹ Both positive (rejection of null hypotheses) and negative (inability to reject null hypotheses) findings have the potential to reduce uncertainty and to inform best practice. Several key steps are typically followed in clinical research.^{2,3} These include: (i) articulation of a refutable, clinically relevant hypothesis motivated by biological plausibility or preliminary research; (ii) design of a targeted experiment with appropriate statistical methods and a suitable sample

size to test the null hypothesis; (iii) specification of the setting, population, intervention, and comparator; (iv) choice of relevant outcomes with appropriate statistical methods; (v) generation of results that provide evidence endorsing or contradicting the null hypothesis; and (vi) interpretation of the results in the context of the existing evidence base.^{2,3} In this issue of the *British Journal of Anaesthesia*, Landoni and colleagues⁴ report the results of a multi-centre randomized study, which tested the following null hypothesis: compared with propofol-based anaesthesia, sevoflurane-based anaesthesia is *not associated*