Letter

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The Authors Reply: Reply on "Evidence Is Enough?: A Systematic Review and Network Meta-Analysis of the Efficacy of Tamsulosin 0.2 mg and Tamsulosin 0.4 mg as an Initial Therapeutic Dose in Asian Benign Prostatic Hyperplasia Patients"

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To the editor:

We thank the interest on our paper 'Evidence Is Enough?: A Systematic Review and Network Meta-Analysis of the Efficacy of Tamsulosin 0.2 mg and Tamsulosin 0.4 mg as an Initial Therapeutic Dose in Asian Benign Prostatic Hyperplasia Patients' [1]. A systematic review and meta-analysis should always be carried out based on a careful consideration of scientific principles. To begin with, we would like to comment on the interpretation of research design.

According to Choi et al. [2], previous studies have demonstrated dissatisfaction among 35.5% of all patients initially treated with 0.2 mg of tamsulosin (TAM). However, it would be an example of the fallacy of hasty generalization to conclude that TAM 0.4 mg would be a better dose since patients show dissatisfaction with TAM 0.2 mg. In order to reach the conclusion that using TAM 0.4 mg as the initial therapy leads to better results than the use of TAM 0.2 mg, it would be necessary to conduct a simultaneous initial treatment with TAM 0.2 mg and TAM 0.4 mg, and then to compare the outcomes between these groups. Thus, as this article [1] collected and analyzed previous studies that used TAM 0.2 mg and TAM 0.4 mg as the initial dose, it should compare the outcomes of these initial doses to draw a valid conclusion. In fact, the most appropriate research design for investigating this hypothesis would be similar to that of Kim et al. [3], who directly compared the use of TAM 0.2 mg to the use of TAM 0.4 mg. However, as most studies do not include a direct treatment comparison, this meta-analysis was conducted with indirect treatment comparison (ITC) and mixed treatment comparison (MTC) in succession.

We argue that Kim et al. [3] is unsuitable for acceptance as a study presenting independent research results for the following reasons: First, if the research of Kim et al. [3] had clinical significance, it would have been published as a full article, rather than an abstract? Therefore, there is considerable room for doubt about the thoroughness of the research. Second, however, as a basic principle for a systematic review and meta-analysis, all existing data should be included, and the least possible data should be excluded. Although the study of Kim et al. [3] is only an abstract, and therefore cannot be considered a high-quality research article, it was included in the MTC analysis as it con-

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tained raw material suitable for that analysis. If Kim et al. [3] is excluded from the meta-analysis, the use of TAM 0.2 mg would lead to favorable results; hence, it would be desirable to include Kim et al. [3], which includes comparative data on the doses of TAM 0.2 mg and TAM 0.4 mg, in order to make an equitable comparison. Finally, and most importantly, no significant difference was found between initial therapy with TAM 0.2 mg and initial therapy with TAM 0.4 mg in the network meta-analysis (NMA) incorporating ITC. However, for a somewhat stricter and more equitable comparison, MTC was conducted by accepting Kim et al. [3], the results of which supported the benefit of TAM 0.4 mg, despite posing some difficulties under the assumptions of NMA. Still, no significant difference between the use of TAM 0.2 mg and TAM 0.4 mg was observed. These considerations are specifically described in the methods, results, and discussion of this study.

Tae et al. [4] made the meaningful observation in their letter that only 3 Asian studies have addressed this issue, and in fact, this meta-analysis had no choice but to analyze differences between clinical practice in the West (0.4 mg) and the East (0.2 mg). However, most of the previous Asian studies — in particular, benign prostatic hyperplasia guidelines in Korea and Japan — have proven the efficacy of TAM 0.2 mg as the initial dose. In conclusion, as no difference between the use of TAM 0.2 mg and TAM 0.4 mg as the initial therapy for Asians was observed in this meta-analysis, the conclusion can be drawn that TAM 0.2 mg is the appropriate initial dose for Asians. Finally, the westernization of the body mass index and body type of Koreans is an indirect form of evidence that does not directly support or contradict the hypothesis. Furthermore, the presence of reporting bias is specifically described in Fig. 6. Excluding the study of Kim et al. [3] would eliminate the reporting bias, so it can be considered the main cause of the reporting bias in this study

The main limitation of this study, as previously described, is that it conducted an MTC despite not meeting the assumptions of NMA. In a strict analysis, it would be desirable to confirm the difference between the doses of 0.2 mg and 0.4 mg of TAM in an ITC. Therefore, if possible, interpretation based on the adjusted indirect comparison shown in Fig. 2 of our study [1] is recommended. Moreover, as indicated in the letter [4], it is difficult to argue for the overall efficacy and safety of TAM because there was no assessment of adverse events. Finally, as was well explained in the letter [4], more research by researchers in the field is required to confirm the appropriate dose of TAM.

• **Conflict of Interest:** No potential conflict of interest relevant to this article was reported.

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