Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals reviewed in this issue

Aust Fam Physician*
BMJ*
Br Homeopath J*
Br J Gen Pract*
Can Fam Physician Med Fam*
Evidence-Based Medicine*
J Fam Pract*
JAMA*
Occup Environ Med*
Physician and Sportsmedicine*
Prim Care*
Sci Am*
*Journals indexed in Index Medicus

Adolescent Health

22-086 Adolescent girls' attitudes toward pregnancy: the importance of asking what the boyfriend wants.

Cowley C, Farley T. J Fam Pract. July 2001. Vol.50. No.7. p.603-7.

Reviewed by Dr Bruce Adlam

Review: This small study evaluated the factors associated with attitudes toward pregnancy among girls presenting to an adolescent health clinic, to better predict which girls are at the highest risk of pregnancy. Most efforts to prevent or delay adolescent pregnancy have been directed at providing birth control, but this intervention is likely to fail if teens are not interested in preventing pregnancy. The best predictor of an adolescent girl's attitude toward pregnancy is her perception of her boyfriend's desire for a baby. These researchers suggest that primary care providers should include boyfriends in any efforts to delay pregnancy in at-risk adolescent girls. Teenagers who are ambivalent about whether they want to be pregnant do not differ significantly from those desiring pregnancy, and should be considered just as high risk.

Comment: There are limitations to this study but it is interesting that studies examining pregnant and parenting adolescents' attitudes toward childbearing suggest that the percentage of pregnancies that are truly unintended may be lower than commonly believed. Bear in mind this is a North American study but it was clear that there were intercultural differences and the difference in attitudes between Mäori and non-Mäori in New Zealand would be of interest.

Anesthesia and Analgesia

22-087 Chronic pain: a challenge for primary care.

Smith BH. Br J Gen Pract. July 2001. Vol.51. No.468. p.524-5.

Reviewed by Dr Rob Henderson

Review: Chronic pain is defined, by the International Association for the Study of Pain, as pain which has persisted beyond the time of normal tissue healing – usually taken to be three months. Pain has a physiological purpose in association with an acute injury. Chronic pain, however, is a maladapted or dysfunctional response and includes physical, psychological, social and emotional components. Most of the studies on chronic pain have been hospital based in pain clinics, which are highly selective. The incidence of chronic pain in the community varies from country to country and within different groups of society. Some studies have found that the incidence of chronic pain in the community is as high as 46%. It is more common in females and the incidence

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About JRS

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The JRS is a guide to current reading in General Practice. Each article reviewed in the JRS has been selected by the reviewer because, in some aspect, it is considered worth reading by general practitioners.

The majority of reviewers are themselves general practitioners. A review in the JRS should not be considered a substitute for reading the original article.

The JRS seeks to extend the range of journals reviewed and always welcomes new reviewers.

The Goodfellow Unit, Faculty of Medicine and Health Sciences, The University of Auckland, would especially like to thank the reviewers and their staff for the time they generously give to the JRS. We would also like to thank the Philson Library (who supply the reprint service), the RNZCGP, and the other sponsors of the JRS.

JRS Reviewers

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increases with age and inability to work. It is also more common in people living in council rented accommodation. These community studies include a large proportion of people with mild pain. Out of these, 16% were considered to have severe pain and 28% had sought professional advice. There is still a lot that is not known about chronic pain and chronic pain can be a challenge to all concerned. It has been shown that while doctors seem to concentrate on relieving the pain, it is the disability which concerns patients most. Further research is needed into this common problem.

Comment: Doesn't provide any new answers to the problem but a good review.

Asthma

22-088 Asthma and COPD: inhalation therapy – clarity or confusion?

Seeto L, Lim S. Aust Fam Physician. June 2001. Vol.30. No.6. p.557-61.

Reviewed by Dr Barry Suckling

Review: Reviews the pros and cons of various inhaler devices to encourage a more tailored choice.

22-089 Puffers and spacers.

Asthma Strategy Group. Aust Fam Physician. June 2001. Vol.30. No.6. p.563.

Reviewed by Dr Barry Suckling

Review: A simple sheet to photocopy for patient information on 'how to use your spacer'.

22-090 Inhaled corticosteroids alone appear to be as effective as oral corticosteroids after emergency department discharge for acute asthma.

Peters J. Evidence-Based Medicine. March/April 2001. Vol.6. No.2. p.45.

Reviewed by Dr Bruce Arroll

Review: This was a systematic review of inhaled corticosteroids with and without oral corticosteroids versus oral corticosteroids. They studied only patients who were discharged after treatment with bronchodilators plus the combination of steroids. There was no difference between the inhaled and oral steroid group and the inhaled group had a higher PEFR at days 20–24. (Original article reviewed: Cochrane Database Syst Rev 2000; 3: CD002316).

Comment: The commentator makes the point that unless someone is at high risk from taking oral steroids then the standard treatment should be five to ten days of oral prednisone. My view is to get the higher PEFR would be to give both oral and inhaled steroids so that the patient gets used to having inhaled steroids.

Cardiovascular System

22-091 Are all the ß-blockers equally effective in reducing mortality after acute myocardial infarction (AMI)?

Dickerson LM, Carek PJ. J Fam Pract. August 2001. Vol.50. No.8. p.652.

Reviewed by Dr Bruce Adlam

Review: Although the impact of ß-blockers on survival after AMI has been well demonstrated, differences among specific ß-blockers have not been evaluated. This study was designed to compare the effectiveness of three ß-blockers (Atenolol, Metoprolol, and Propranolol) on survival after AMI. Overall, ß-blocker therapy in patients following a myocardial infarction produces a substantial decrease in mortality over the following two years (13%–15% vs 23%). Atenolol and Metoprolol perform similarly. Propranolol may be slightly less effective. (Original article reviewed: Am J Cardiol 2001; 87: 823-6).

22-092 Chelation therapy for ischemic heart disease: a randomized controlled trial.

Knudtson ML, Wyse DG, Galbraith PD, et al. JAMA. 23/30 January 2002. Vol.287. No.4. p.481-6.

Reviewed by Dr Len Brake

Review: Chelation therapy using EDTA is widely used as an alternative treatment for coronary artery disease. A double blind randomised placebo-controlled trial was conducted between 1996 and 2000. Eighty-four patients with angina and ST depression on a standard treadmill test were included. Patients were randomly assigned either an infusion of 40 mg/kg EDTA or a placebo infusion twice weekly for 15 weeks. Objective measurement was made over six months using a treadmill. Exercise capacity and quality of life scores improved similarly in both groups.

Comment: There was no evidence to support a beneficial effect of chelation.

22-093 Medical management of advanced heart failure.

Nohria A, Lewis E, Stevenson LW. JAMA. 6 February 2002. Vol.287. No.5. p.628-40.

Reviewed by Dr Len Brake

Review: A data search for randomised controlled trials from the past 20 years is reported. ACE inhibitors and Beta Blockers can slow disease progression and improve survival but dosage adjustment is delicate. (Patient Page attached)
Comment: End of life care is discussed including (God forbid) inactivation of implantable defibrillators.

22-094 ABC of arterial and venous disease: Acute stroke.

Bath PM, Lees KR. BMJ. 1 April 2000. Vol.320. No.7239. p.920-3.
Reviewed by Dr Martin Tooke
Review: Part of an ABC series in the BMJ on arterial and venous disease. (See 22-095 and 22-096).
Comment: Thought provoking. The authors assert that all patients with acute stroke should be assessed immediately at hospital – bypassing their GP, if necessary, to save time. Assessment should include, they suggest, an urgent CT head scan.

22-095 ABC of arterial and venous disease: Secondary prevention of transient ischaemic attack and stroke.

Lees KR, Bath PM, Naylor AR. BMJ. 8 April 2000. Vol.320. No.7240. p.991-4.
Reviewed by Dr Martin Tooke
Review: A concise review (see 22-094 and 22-096).
Comment: Highly recommended reading. Does dipyridamole plus aspirin work better than aspirin alone for stroke prevention? When is a duplex ultrasound scan of the carotids indicated? When is echocardiography indicated in a patient who has had a stroke? How should you manage hypertension in a patient who had a stroke two weeks previously? What's the risk of having a stroke if you've had a TIA? Or a retinal artery occlusion? You'll find answers to (most of) these questions here.

22-096 ABC of arterial and venous disease: Swollen lower limb - 1: General assessment and deep vein thrombosis.

Gorman WP, Davis KR, Donnelly R. BMJ. 27 May 2000. Vol.320. No.7247. p.1453-6.
Reviewed by Dr Martin Tooke
Review: Part of an ABC series in the BMJ on arterial and venous disease. (see 22-094 and 22-095).
Comment: If you want to read a review article on diagnosis of deep vein thrombosis (including differential diagnosis), then this is highly recommended. There are also some comments on treatment.

22-097 Current management of acute ischemic stroke: Part 1: Thrombolytics and the 3-hour window.

Herd AM. Can Fam Physician Med Fam Can. September 2001. Vol.47. p.1787-93.
Reviewed by Dr Mike Lyons
Review: See 22-098.

22-098 Current management of acute ischemic stroke: Part 2: Antithrombotics, neuroprotectives, and stroke units.

Herd AM. Can Fam Physician Med Fam Can. September 2001. Vol.47. p.1795-800.
Reviewed by Dr Mike Lyons
Review: Part 1 reviews thrombolysis with tissue plasminogen activator and an organised system of emergency treatment. It is critical to identify the 5–10% of strokes that are haemorrhagic. Four major random controlled trials are quoted as well as a meta-analysis of 17 others. Tables include inclusion criteria for thrombolytic therapy, absolute and relative contraindications and chain of survival and recovery. These lead to the figure of 30–40% chance of a patient achieving a full recovery versus the 4% chance of a symptomatic intracranial haemorrhage. Treatment within three hours of onset appears crucial. Other parameters are: assessment at hospital by a physician within 10 minutes of arrival, CT scan within 25 minutes and treatment with 60 minutes. An assumption is that neurological and neurosurgical expertise is on tap! (see 22-097). Part 2 is less specific. Routine anticoagulation is no longer advocated. Low dose aspirin has a modest benefit and less is known about other antiplatelet agents. Experimental neuroprotective agents are skimmed over. Evidence suggests dedicated care for stroke victims in specialised units or by a stroke team on an acute medical ward reduces disability and mortality in a cost effective manner. Factors involved are debated.
Comment: The dilemma is focused by the conclusion of Part 1 'Everyone involved must abandon the old nihilistic attitudes about stroke' being dampened by the cautious statement at the end of Part 2 'active management of stroke is an emerging discipline with many potential therapies still at an experimental stage'.

Communicable Diseases, Infections and Parasites

22-099 Varicella disease after introduction of varicella vaccine in the United States, 1995–2000.

Seward JF, Watson BM, Peterson CL, et al. JAMA. 6 February 2002. Vol.287. No.5. p.606-11.
Reviewed by Dr Len Brake
Review: With rumours that a varicella vaccine may become an optional extra to childhood immunisation in New Zealand this is a timely article. Active varicella surveillance was carried out among population groups where the vaccine was introduced in 1995. The immunisation rate was approx 80%. Dramatic reductions are recorded in cases notified – declines of 71%–84%, and a tenfold decrease in hospital admissions.
Comment: The cost of achieving this will need to be assessed.

Dermatology

22-100 Antibiotics as an adjunct to phenol matrixectomy did not decrease healing time of ingrown toenails.

Goldberg AS. Evidence-Based Medicine. May/June 2001. Vol.6. No.3. p.92.
Reviewed by Dr Bruce Arroll

Review: In this study patients with ingrown toenails had either a matrixectomy with phenol and antibiotics, matrixectomy with antibiotics a week later, or a matrixectomy alone. The matrixectomy alone was as good as the matrixectomy with immediate antibiotics and better than the group who had antibiotics a week later. (Original article reviewed: Arch Fam Med 2000 Sep /Oct; 9: 930-2).
Comment: Nice to see another procedure that does not require antibiotics. I may have an even better technique that requires no surgery (no controlled evidence). Put a band-aid on toe overnight then the next day stuff a wad of cotton wool in to the corner of the nail. This lifts the nail and within a few days the inflammation settles down. Then encourage the patient to cut nails properly. I have not had to do a matrixectomy since starting to use this. More comments on email b.arroll@auckland.ac.nz

Ear, Nose and Throat

22-101 Otitis externa in UK general practice: a survey using the UK General Practice Research Database.

Rowlands S, Devalia H, Smith C, et al. Br J Gen Pract. July 2001. Vol.51. No.468. p.533-8.
Reviewed by Dr Rob Henderson
Review: This study extracted and examined data from contributing practices in the UK General Practice Research Database. The study found that otitis externa was a common condition, occurring at all ages. It was slightly more frequent in females and has a seasonal variation. Eardrops were prescribed in 85% of cases, usually steroid or steroid antibiotic combination. Oral antibiotics were prescribed in 21% of cases. Referral to secondary care accounted for 3% of cases.
Comment: The study examines a common condition. No new knowledge but confirms what GPs do.

22-102 A systematic review of vertigo in primary care.

Hanley K, O'Dowd T, Considine N. Br J Gen Pract. August 2001. Vol.51. No.469. p.666-71.
Reviewed by Dr Rob Henderson
Review: This article surveys the literature on this common subject in primary care and examines the evidence on which clinical decisions could be made. The most frequent causes of vertigo in general practice are benign positional vertigo, acute vestibular neuronitis, and Meniere's disease. However, vascular incidents and neurological causes such as multiple sclerosis must be kept in mind. Vestibular sedatives are not recommended for prolonged use in vertigo. There is a need for further research in general practice.
Comment: There is a good description of each of these conditions causing vertigo and this is a good article to keep for reference.

22-103 Some non-antibiotic treatments are effective for relieving acute sore throat.

Little P. Evidence-Based Medicine. May/June 2001. Vol.6. No.3. p.82.
Reviewed by Dr Bruce Arroll
Review: This paper is a systematic review of non-antibiotic treatments for sore throat. Benefits were found from Ibuprofen, other NSAIDs, paracetamol, super colonisation with benign bacteria, and better doctor-patient communication. (Original article reviewed: Br J Gen Pract 2000 Oct 21; 321: 1007-11).
Comment: This review gives us a lot of possibilities for treating viral sore throats with medicines other than antibiotics, although not all of them were done in primary care settings.

22-104 Pseudoephedrine and acetaminophen relieved sinus symptoms in the course of the common cold.

Bridges-Webb C. Evidence-Based Medicine. July/August 2001. Vol.6. No.4. p.120.
Reviewed by Dr Bruce Arroll
Review: This study is a randomised controlled trial of pseudoephedrine with paracetamol (PHA) versus placebo on patients with sinus like pain of at least moderate severity. Those in the PHA group had fewer sinus symptoms at two hours after the second dose (six hours apart). (Original article reviewed: Arch Fam Med 2000 Nov/Dec; 9: 979-85).
Comment: The commentator was more pessimistic than expected but had some genuine concerns: (a) not sure how many patients felt better; only had their scores to go on, (b) not sure which drug was creating the benefit, (c) he was not sure if the side-effects were worth the benefits. My view is that this gives some evidence for not needing antibiotics for all cases of sinusitis.

22-105 Does delaying placement of tympanostomy tubes have an adverse effect on developmental outcomes in children with persistent middle ear effusions?

Stephens MB. J Fam Pract. August 2001. Vol.50. No.8. p.651.
Reviewed by Dr Bruce Adlam
Review: Middle ear effusion has historically raised concern for potential delays in child development. Persistent otitis media with effusion (OME) is, therefore, the primary indication for tympanostomy tube placement. This non-blinded randomised clinical trial provides compelling evidence that placement of tympanostomy tubes at the time of diagnosis in otherwise healthy children with persistent OME is no more effective than withholding treatment for up to nine months. In this setting, early surgical intervention has no effect on cognitive development, language acquisition and development, or behaviour. (Original article reviewed: N Engl J Med 2001; 344:1179–87).

Emergency Medicine

22-106 Dislocated shoulder: the Mount Beauty analgesia-free method.

Zagorwski M. Aust Fam Physician. June 2001. Vol.30. No.6. p.570.
Reviewed by Dr Barry Suckling

Review: This technique reduces anterior shoulder dislocation without the need for any sedating or narcotic analgesics. It would be very helpful in remote situations and is ideal for recurrent dislocation.

Endocrinology

22-107 Combination therapy with candesartan and lisinopril was more effective than monotherapy in type 2 diabetes and hypertension.

Fisher M. Evidence-Based Medicine. July/August 2001. Vol.6. No.4. p.109.
Reviewed by Dr Bruce Arroll

Review: This RCT compared Candesarten 16 mg and Lisinopril 20 mg, or together, or together for the last 12 of the 24 weeks. After 24 weeks the average reduction in systolic blood pressure was 14.1 mm Hg for Candesarten, 16.7 mmHg for Lisinopril and 25.3 mmHg for the combination. There was a greater mean reduction in urinary albumin for the combination than Candesarten alone but not for Lisinopril alone. (Original article reviewed: BMJ 2000 Dec 9; 321: 1440-4).

Comment: If you are having trouble lowering blood pressure the combination of an ACE and an angiotensin II blocker are worth considering.

22-108 Screening for microalbuminuria to prevent nephropathy in patients with diabetes: A systematic review of the evidence.

Scheid DC, McCarthy LH, Lawler FH, et al. J Fam Pract. August 2001. Vol.50. No.8. p.661-8.
Reviewed by Dr Bruce Adlam

Review: This study evaluated whether screening patients with diabetes for microalbuminuria (MA) is effective according to the criteria developed by Frame and Carlson and those of the US Preventive Services Task Force. Screening for MA meets only four of six Frame and Carlson criteria for evaluating screening tests. The recommended strategies to overcome diagnostic uncertainty by using repeated testing are based on expert opinion, are difficult to follow in primary care settings, do not improve diagnostic accuracy sufficiently, and have not been tested in a controlled trial.

Comment: The researchers found no controlled trials of screening to prevent progression to nephropathy. Because of the high incidence of nephropathy and ESRD, MA screening in patients with type 1 diabetes is probably cost-effective. Screening persons with type 2 diabetes for MA is less certain. Analyses have generally not considered imperfect testing or the impact of sequential testing strategies. Based on studies that have demonstrated delayed progression in persons with diabetes who have normoalbuminuria, three cost-effectiveness analyses found that routine use of ACEIs compared favorably with MA screening. There is a large useful bibliography attached to this review and a good commentary on screening for microalbuminuria in the same issue. (See 22-109 and 22-110).

22-109 Use of microalbuminuria testing in persons with type 2 diabetes: Are the right patients being tested?

Hueston WJ, Scibelli S, Mainous AG. J Fam Pract. August 2001. Vol.50. No.8. p.669-73.
Reviewed by Dr Bruce Adlam

Review: See 22-108.

22-110 Screening for microalbuminuria.

Peterson KA. J Fam Pract. August 2001. Vol.50. No.8. p.674-5.
Reviewed by Dr Bruce Adlam

Review: See 22-108.

Family Practice

22-111 Getting the best out of general practice – an open letter to the Minister of Health.

Jewell D. Br J Gen Pract. July 2001. Vol.51. No.468. p.523-4.
Reviewed by Dr Rob Henderson

Review: Many GPs feel the Department of Health now considers them as part of the problem in delivering high quality health care rather than part of the solution. They feel they are regarded as the enemy. The authors argue that GPs, far from being hostile, remain committed to the principle of universal, high quality service, free at the point of delivery. One-fifth of the NHS's total budget goes on primary care, but more than 90% of all patient contacts take place in primary care. The problem is that it is difficult to do the job properly with eight- to ten-minute consultations. Nurses have been shown to do some of the tasks doctors perform, however, extensive areas of the work cannot be transferred to nurses without thorough training, proper evaluation or adequate resourcing. There is also a need for trials to occur before new strategies are adopted. Part of the problem in the NHS is a shortage of doctors. Change is inevitable but it must be well researched and resourced.

Comment: A thoughtful well-researched article.

22-112 Frequent attenders in general practice: a retrospective 20-year follow-up study.

Carney TA, Guy S, Jeffrey G. Br J Gen Pract. July 2001. Vol.51. No.468. p.567-9.
Reviewed by Dr Rob Henderson

Review: The study identified 58 patients who had been frequent attenders in the year 1975 (i.e. attended more than 12 times in one year) and then examined the consultation behaviour of these patients over the subsequent 20 years. The study found that frequent attending is not consistent. The majority of high attenders revert over a short period of time to a normal consulting pattern. Diseases rather than patients appear to dictate high consulting rates. Consistently high attending was largely due to multiple pathology in this study.

Comment: This is an important addition to the study of frequent attenders.

22-113 James MacKenzie Lecture: Trust – in general practice.

Fugelli P. Br J Gen Pract. July 2001. Vol.51. No.468. p.575-9.
Reviewed by Dr Rob Henderson

Review: Trust often implies a transference of power to a person or to some system to act on one's behalf or in one's best interest. Sick people have always needed a particular form of trust, because being ill implies a loss of trust in yourself, in your body, in your social role, and/or in your future. This loss of trust fortifies a need to trust others, among them, the doctor. In the modern world research indicates that the majority of patients still trust their personal doctor, whereas confidence in health care systems is under strain. Fugelli goes on to examine what trust consists of and feels that it involves several ingredients; a just society, moral integrity, personal doctoring, sharing of power, compassion, realistic medicine and competence. The law makers, politicians, bureaucrats, the health authorities and the market economy ideals tempt us to deviate from our professional traits and betray the very basis of trust in general practice. We must stand firm and not allow this to happen.

Comment: If you are disillusioned with general practice, read this. It's good medicine for disillusioned doctors.

22-114 General practice in an age of measurement.

Roland M. Br J Gen Pract. August 2001. Vol.51. No.469. p.611.
Reviewed by Dr Rob Henderson

Review: Governments across the world are trying to measure the quality of GP services. Most of the things that general practitioners do are diverse and difficult to define. Hospital admission rates and prescribing data are not always indicators of quality of care. Good communication and attention to interpersonal care, integration of care and co-ordination of care are probably all more important aspects of what GPs do. These things are, however, very difficult to measure and are consequently often overlooked.

Comment: The article raises fundamental issues for general practice.

22-115 General practice out-of-hours service, variations in use and equality in access to a doctor: a cross-sectional study.

O'Reilly D, Stevenson M, McCay C, et al. Br J Gen Pract. August 2001. Vol.51. No.469. p.625-9.
Reviewed by Dr Rob Henderson

Review: The study examines the geographical variations in the rates of the out-of-hours calls and the response to calls. Most patients who contacted the co-operative did not get a face-to-face consultation from their GP but received only telephone advice. Consultation at the centre or a home visit were strongly related to age. Queries concerning young patients were much more frequent than those about older people. However, fewer than 10% of young patients received home visits while about 50% of those over 85 did.

Patients from deprived areas were also more likely to be seen by the doctor. The likelihood of a face-to-face consultation with the doctor decreased with the further the patient lived from the primary care centre. A patient living 34 km from the centre had about half the chance of having a face-to-face consultation with the GP compared with a patient living on the doctor's doorstep.
Comment: This is an important and well-done study. Would be useful for people running these centres.

22-116 Practice size: impact on consultation length, workload, and patient assessment of care.

Campbell JL, Ramsay J, Green J. Br J Gen Pract. August 2001. Vol.51. No.469. p.644-50.
Reviewed by Dr Rob Henderson
Review: This study examined 54 practices in two inner London areas. Patients' satisfaction with practice services and detailed information about practices were obtained from postal questionnaires. Patients from smaller practices reported improved accessibility to care, receptionist performance, and better continuity of care than larger practices. The smaller practices did not show any disadvantages in respect of 10 other criteria of clinical care. Practices with a smaller number of patients per doctor had longer consultations and higher ratings of patient satisfaction. The authors comment that health planners need to pay more attention to what patients feel about practices.
Comment: This is an interesting study as many planners assume that bigger practices are better but there is little evidence for this as this study shows.

22-117 Reasons for patient removals: results of a survey of 1 005 GPs in Northern Ireland.

O'Reilly D, Gilliland A, Steele K, et al. Br J Gen Pract. August 2001. Vol.51. No.469. p.661-3.
Reviewed by Dr Rob Henderson
Review: This study examined the reasons why doctors removed patients, in the last two years, from their practice. Out of the 1 005 doctors surveyed 399 had removed a patient from their list. The commonest reasons cited were: violence or threatening behaviour in 49% of cases, unreasonable demands in 17%, and fraud in 13%. Doctors, in the UK, can remove a patient from their list without giving a reason. This subject has become a hot issue recently, as some people believe doctors should not be able to remove a patient without getting approval.
Comment: This is an important issue when considering capitation.

Gastroenterology

22-118 Helicobacter pylori testing plus eradication was as effective and safe as prompt endoscopy for dyspepsia.

Veldhuyzen van Zanten SJ. Evidence-Based Medicine. March/April 2001. Vol.6. No.2. p.48.
Reviewed by Dr Bruce Arroll
Review: Patients were placed in one of two groups; (a) tested for H pylori using the breath test (test and treat group) or (b) rapid endoscopy and treated as a result of the findings. There were no differences between the two groups for GI symptoms, quality of life, symptom improvement, GP visits or sick days. There were more dissatisfied patients at the end of the study, 12% vs 4%, for the test and treat group. There was less endoscopy in the test and treat group but more eradication treatment. (Original article reviewed: Lancet 2000 Aug 5; 356: 455-60).
Comment: For the NZ GP the problem here is not having access to fully funded H pylori breath testing, which costs patients about $80. As this is a better test than the serum test it is not possible to generalise this study to patients having blood tests for H pylori.

22-119 Treatment of peptic ulcer disease and nonulcer dyspepsia.

Meurer LN. J Fam Pract. July 2001. Vol.50. No.7. p.614-9.
Reviewed by Dr Bruce Adlam
Review: This article looks at the latest evidence and treatment of peptic ulcer and non-ulcer dyspepsia. The authors look at the cost effectiveness of test and treat strategy for peptic ulcer disease but in their discussion of non-ulcer dyspepsia there is still no clear cut benefit for empiric treatment of H Pylori.
Comment: Quite a good article but most likely to be covered by our own dyspepsia guidelines.

22-120 Management of gastro-oesophageal reflux disease in general practice.

Dent J, Jones R, Kahrilas P, et al. BMJ. 10 February 2001. Vol.322. No.7282. p.344-7.
Reviewed by Dr Martin Tooke
Review: As the title suggests, an article on the management of gastro-oesophageal reflux in general practice.
Comment: There are many reviews and guidelines available covering this subject. I thought this clinical review was more useful than most.

Genetics

22-121 The first human cloned embryo.

Cibelli JB, Lanza RP, West MD, et al. Sci Am. January 2002. Vol.286. No.1. p.42-9.
Reviewed by Dr Ron Vautier
Review: Enucleated human egg cells injected with cumulus cells have been induced to divide to four to six cell embryos. Also, immature eggs have been induced to divide without fertilisation (parthenogenesis). The aim is to obtain therapeutically useful stem cells. Also discussed are the ethical implications of such research.
Comment: This up to the minute, straight from the horse's mouth, but possibly somewhat biased reporting. Read it to get a very clear view of what is going on in this area.

Gynaecology

22-122 The community prevalence of chronic pelvic pain in women and associated illness behaviour.

Zondervan KT, Yudkin PL, Vessey MP, et al. Br J Gen Pract. July 2001. Vol.51. No.468. p.541-7.
Reviewed by Dr Rob Henderson
Review: Women aged between 18 and 49 were surveyed by a postal questionnaire on their experience of pelvic pain. The study found 24% of women experienced chronic pelvic pain. Chronic pelvic pain was defined as recurrent or constant pain lasting for at least six months unrelated to periods, intercourse or pregnancy. In one-third of the women the pain had started five or more years previously. Forty-one per cent of women had never consulted anyone about their symptoms. Many women, however, expressed anxiety about the cause of their symptoms and the authors felt that there is a need for more information for these patients.
Comment: This study emphasises the importance and the frequency of this disabling condition.

22-123 Selective serotonin reuptake inhibitors reduce symptoms in premenstrual syndrome.

Smith RC. Evidence-Based Medicine. May/June 2001. Vol.6. No.3. p.75.
Reviewed by Dr Bruce Arroll
Review: This review found a benefit from fluoxetine and sertraline for both physical and behavioural symptoms. Typical dosings were 20 mg fluoxetine for two to three cycles or 100 mg sertraline in luteal phase for three cycles or 50–100 mg for two cycles. (Original article reviewed: Lancet 2000 Sep 30; 356: 1131-6.)
Comment: The commentator makes the point that there are behavioural therapies that also work such as cognitive behavioural techniques and careful attention to provider-patient relationship.

22-124 A levonorgestrel releasing intrauterine system was more cost effective than was hysterectomy for menorrhagia.

Khan KS. Evidence-Based Medicine. July/August 2001. Vol.6. No.4. p.127.
Reviewed by Dr Bruce Arroll
Review: This study randomised women eligible for a hysterectomy to receiving a levonorgestral IUD (LNG IUD) or hysterectomy. At one year there was no difference between the groups except the LNG IUD group experienced more pain. In terms of cost-effectiveness the LNG IUD was much better. (Original article reviewed: Lancet 2001 Jan 27; 357: 273-7).
Comment: Each LNG IUD costs over $400. However, some gynaecology departments will insert them. You may need to rattle the cage of your local hospital to get them. Hopefully they will be stocking them to cut down their rates of hysterectomy.

22-125 Quality-of-life and depressive symptoms in postmenopausal women after receiving hormone therapy: results from the Heart and Estrogen/Progestin Replacement Study (HERS) trial.

Hlatky MA, Boothroyd D, Vittinghoff E, et al. JAMA. 6 February 2002. Vol.287. No.5. p.591-7.
Reviewed by Dr Len Brake
Review: Effects of post menopausal hormone therapy on quality of life are undocumented. Articles relate to effect on disease prevention. One of the drawbacks is the paucity of measuring tools for quality of life. The HERS trial finds that the presence or absence of flushing at the time of onset of treatment defines the outcome. Those without flushing had greater declines in physical function and energy than those with flushing. See 22-126 for editorial comment.
Comment: Otherwise, to be honest, there was not much in it.

22-126 Postmenopausal hormone therapy and quality of life: No cause for celebration.

Rexrode KM, Manson JE. JAMA. 6 Feburary 2002. Vol.287. No.5. p.641-2.
Reviewed by Dr Len Brake
Review: See 22-125.

Homeopathy

22-127 Homeopathy in acute otitis media in children: treatment effect or spontaneous resolution?

Frei H, Thurneysen A. Br Homeopath J. October 2001. Vol.90. No.4. p.180-2.
Reviewed by Dr Mimi Irwin
Review: The purpose of this trial was to measure how many children using homeopathy and having the diagnosis of acute otitis media were pain free in 12 hours or less compared to the placebo group. The study group had 230 patients and 166 were prescribed homeopathy. Resolution of symptoms using homeopathic medication compared with placebo appeared to be more rapid. Homeopathic treatment was cheaper by 14% than conventional treatment. Recurrent otitis media is less frequent in the homeopathic treated group when compared with the antibiotic treated children.
Comment: Interesting study, good to see larger patient numbers. The homeopathic consultation took 5–10 minutes longer than a conventional consultation. The most common and effective homeopathic medications were: Pulsatilla, Belladonna, Sulphur, Phosphorus, Calcium carbonate and Lycopodium.

Immunology and Allergy

22-128 Pitfalls of 'inert' ingredients.

Millar JS. Br J Gen Pract. July 2001. Vol.51. No.468. p.570.
Reviewed by Dr Rob Henderson
Review: A patient had an allergic reaction when taking aspirin then subsequently had another allergic reaction when taking erythromycin. It was discovered that the allergic reaction in both cases was not due to the drug but due to an 'inert' ingredient common to both drug preparations. Doctors frequently assume that reactions following the taking of a drug are due to the drug, and its avoidance is all that is necessary. However, if the reaction was to an inert substance in the medication, patients will react to all other medications with the same inert material. There is a lack of information in most drug inserts about inert materials. Some of the same inert ingredients

also occur in a number of over-the-counter medications. Many of the inert ingredients are not necessary – they are colouring or other additives and could be dispensed with. There have been calls for dispensing with these unnecessary additives.

Comment: This is an important and little known area that the author has introduced. Well worth reading.

22-129 Routine primary immunisation using a longer needle resulted in fewer local reactions in infants.

Forster J. Evidence-Based Medicine. July/August 2001. Vol.6. No.3. p.117.

Reviewed by Dr Bruce Arroll

Review: This was a trial of 25mm needles or a 16mm length needle. There were fewer reactions at the site in the group with the longer needles. (Original article reviewed: BMJ 2000 Oct 14; 321: 931-3).

Comment: The commentator makes the point that this study was using older, more allergenic vaccines. However, he still endorsed the longer needles except for premature infants with birth weights less than 1500 gms.

Musculoskeletal System

22-130 What is the best treatment for patients with symptomatic mild-to-moderate hallux valgus (bunions)?

Oliver MN. J Fam Pract. August 2001. Vol.50. No.8. p.718.

Reviewed by Dr Bruce Adlam

Review: Approximately 33% of adults have some degree of hallux valgus deformity (bunion of the great toe). The options include orthosis or watchful waiting. Surgical treatment of mild-to-moderate hallux valgus results in less pain and disability than either the use of orthotics or watchful waiting. However, patients were not blinded and there is a possibility of bias in favour of surgery. (Original article reviewed: JAMA 2001; 285: 2474-80).

Comment: Although surgery provided superior outcomes, its cost and workday losses are a significant detriment. A trial of orthotics or watchful waiting is worth considering.

22-131 Managing low-back pain: Steps to optimize function and hasten return to activity.

Drezener JA, Herring SA. Physician and Sportsmedicine. August 2001. Vol.29. No.8. p.37-43, 67-8.

Reviewed by Dr Rob Campbell

Review: A useful summary paper for the assessment and management of non-disc prolapse low back pain. Rehabilitation is discussed and specific exercises shown in an accompanying patient handout.

Comment: A helpful paper from one of America's gurus on back pain. Handouts for patients are excellent.

Neurology

22-132 Does this patient have temporal arteritis?

Smetana GW, Shmerling RH. JAMA. 2 January 2002. Vol.287. No.1. p.92-101.

Reviewed by Dr Len Brake

Review: Journals over the past 30 years have been scrutinised to assess the diagnostic value of particular signs and symptoms in temporal arteritis. Most of the well known identifiers are surprisingly unhelpful. Ironically the most useful finding is a normal ESR which makes the diagnosis unlikely.

Nutrition

22-133 Ergogenic supplements and health risk behaviors.

Stephens MB, Olsen C. J Fam Pract. August 2001. Vol.50. No.8. p.696-9.

Reviewed by Dr Bruce Adlam

Review: This cross-sectional study studied the prevalence of ergogenic supplement use in a young healthy population and examined the extent to which supplement use is associated with specific health risk behaviours. Creatine is currently the most popular dietary ergogenic supplement. The reported benefits of creatine include increased energy during short-term intense exercise, increased muscle mass, increased strength, in-

creased lean body mass, and decreased lactate accumulation during intense exercise.

Comment: Individuals who used ergogenic supplements were more likely to drink alcohol, drink heavily, more likely to drive or ride in a vehicle with someone who had been drinking and more likely to have been in a physical fight compared with those who had not used supplements. Men were more likely to use supplements than women. There were no differences in patterns of supplement use according to age or body mass index.

Obstetrics

22-134 What is the optimal protocol for diagnosis of ectopic pregnancy?

Abrahamson L, Newton W. J Fam Pract. July 2001. Vol.50. No.7. p.570.

Reviewed by Dr Bruce Adlam

Review: Ectopic pregnancy is a major cause of morbidity and mortality in women of reproductive age. This study used a hypothetical cohort of 10 000 women with first trimester pregnancies (positive pregnancy test result) who presented to an inner-city emergency department with abdominal pain or bleeding and six diagnostic algorithms. This decision analysis provides fair evidence that transvaginal US followed by quantitative HCG is the optimal strategy for diagnosing ectopic pregnancy. Obtaining HCG before ultrasound also performs very well. (Original article reviewed: Obstet Gynecol 2001; 97: 464-70).

22-135 Is ginger root effective for decreasing the severity of nausea and vomiting in early pregnancy?

Jackson EA. J Fam Pract. August 2001. Vol.50. No.8. p.720.

Reviewed by Dr Bruce Adlam

Review: Nausea and vomiting are both common and a source of distress for women in early pregnancy. As the cause is uncertain, numerous treatments are used empirically. Natural products are appealing because of the concern about the possible teratogenic effects of drugs. This very brief (four days) well-designed study demonstrates that an extemporaneous preparation of ginger root powder is well tolerated and helps relieve the severity of nausea and decreases vomiting episodes in early pregnancy. Usual caveats apply regarding variable sources and dosages. This study was 1-2 gms daily. (Original article reviewed: Obstet Gynecol 2001; 97: 577-82).

Comment: The study did not address long-term safety.

Occupational Health

22-136 Hepatitis A in workers exposed to sewage: a systematic review.

Glas C, Hotz P, Steffen R. Occup Environ Med. December 2001. Vol.58. No.12. p.762-8.

Reviewed by Dr Alastair K Wilson

Review: A review of 17 studies to assess whether the scientific literature supports the hypothesis that workers exposed to sewage are at a higher risk of Hepatitis A. These studies show no increased risk and imply that systematic Hepatitis A vaccination of every worker exposed to sewage will have little effect on the incidence of clinical Hepatitis A.

Comment: A good review that kicks that old myth.

Oncology

22-137 A view from the other side - A doctor's experience of having lymphoma.

Silagy C. Aust Fam Physician. June 2001. Vol.30. No.6. p.547-9.

Reviewed by Dr Barry Suckling

Review: The personal experience of a doctor becoming a patient.

Comment: Being a doctor does not guarantee easy access to good advice and appropriate medical treatment. Finding a GP you trust, even if you are not sick, is important. The experience of being a patient, can teach important lessons about the way we work as doctors.

Palliative Treatment

22-138 The primary care physician and palliative care.

Melvin TA. Prim Care. June 2001. Vol.28. No.2. p.239-47.

Reviewed by Dr M Hewitt

Review: The article outlines the purposes and differences palliative care means to the patient and the process of dying. The curative model of medical care is not applicable but the alleviation of suffering and quality of life issues are paramount. A good case study is given.

Comment: The issues of financial ruin are more applicable in the US situation than in NZ but the concept of abandoning the curative model for a palliative one remains the same.

22-139 Breaking bad news and discussing death.

Ambuel B, Mazzone MF. Prim Care. June 2001. Vol.28. No.2. p.249-67.

Reviewed by Dr M Hewitt

Review: Case studies and a good discussion on how to handle a distressing situation for both patient and doctor. Care and sensitivity are needed along with direction and a plan for the future.

Comment: Often one hears the comment 'they never taught this in medical school'. However, in this area of medical education this situation has been rectified. For some this article will be insightful in that it covers new ground.

22-140 Pain assessment and management.

Abrahm JL, Snyder L. Prim Care. June 2001. Vol.28. No.2. p.269-97.

Reviewed by Dr M Hewitt

Review: Assessment involves the use of an excellent history and the use of visual analogue scales as tools. The types of pain such as nociceptive, somatic, visceral and neuropathic each require their own specific management for optimum treatment. What the pain means to the patient and the variable capacity to absorb information given is discussed.

Comment: Useful 'recipes' for significant pain relief are given, along with

discussion of side-effects, both wanted and unwanted.

22-141 Nonpain symptom management.

Frederich ME. Prim Care. June 2001. Vol.28. No.2. p.299-316.
Reviewed by Dr M Hewitt
Review: Non-pain symptom management involves dealing with the known consequences of the disease process as well as the palliative treatment given. In particular, side-effects from pain relief being the main area involved.

22-142 Management of emergent conditions in palliative care.

Wrede-Seaman LD. Prim Care. June 2001. Vol.28. No.2. p.317-28.
Reviewed by Dr M Hewitt
Review: The common emergencies include intractable pain, cord compression syndromes, superior vena cava syndrome, hypercalcaemia, acute dyspnoea, seizures, haemorrhage and psychiatric episodes. The management of these is much the same as in non-terminal cases with the proviso that the patient is fully informed and any treatment instituted is in their best interests given the circumstances.
Comment: Regardless of the situation, the aim of good palliative care must always be a good death.

22-143 The process of dying and managing the death event.

Twaddle ML. Prim Care. June 2001. Vol.28. No.2. p.329-38.
Reviewed by Dr M Hewitt
Review: The final stages require 'intensive' care without the accoutrements of technology. Essentially a human interactive process with the physician, the patient and the family. Well-managed palliative care and symptom relief play an important part for quality end of life. Grief, anger and bereavement can be alleviated with presence and thoughtful, reassuring comments.
Comment: This is becoming an important part of primary care for families that choose care at home or hospice.

22-144 Chronic illnesses and the end of life.

McGrew DM. Prim Care. June 2001. Vol.28. No.2. p.339-47.
Reviewed by Dr M Hewitt
Review: A brief summary of the types of chronic diseases which become terminal and how best the process can be managed.
Comment: Motor neurone, emphysema, cystic fibrosis, congestive heart failure, all become terminal but recognising the changes is occasionally difficult for the practitioner.

22-145 Pediatric palliative care.

Chaffee S. Prim Care. June 2001. Vol.28. No.2. p.365-90.
Reviewed by Dr M Hewitt
Review: The author outlines the special issues concerning paediatric palliative care for the primary care provider. A collaborative team approach is recommended.
Comment: Often the primary care provider is excluded when the hospital and hospital-based care providers take over. This should not be the case and the article reinforces the value of the family care provider for the whole process.

22-146 Ethical and legal issues in palliative care.

Rousseau P. Prim Care. June 2001. Vol.28. No.2. p.391-400.
Reviewed by Dr M Hewitt
Review: The author reviews controversial issues such as withholding of life-sustaining treatment and physician assisted suicide. While not taking a firm stand on the issues presented in a critical sense, he does not advocate anything which will harm the patient in the broadest sense of the meaning. These issues and others are discussed in the context of the four main ethical doctrines of palliative care: beneficence, non-maleficence, autonomy and justice.

22-147 Intercultural differences and communication at the end of life.

Hallenbeck JL. Prim Care. June 2001. Vol.28. No.2. p.401-13.
Reviewed by Dr M Hewitt
Review: The article discusses common misunderstandings which arise from intercultural beliefs. These can cause conflict and unnecessary emotional trauma for both the families concerned and their primary care physician. The author describes ways to facilitate communication and promote understanding.
Comment: NZ students and doctors are given a broad and frequent exposure to other cultural beliefs and practices in health care. Mäori and Pacific Island people's sensitivities are known and appreciated.

22-148 Grief and bereavement.

Zeitlin SV. Prim Care. June 2001. Vol.28. No.2. p.415-25.
Reviewed by Dr M Hewitt
Review: The author reviews the process of grieving with the dying and terminally ill with emphasis on positive, helpful interventions from attending physicians. Particular care is necessary for the families with children and their grief response.
Comment: A complex issue, with some valuable insights offered from obvious first-hand experience.

Paediatrics

22-149 Urinary tract infections in children.

Kumar RK. Aust Fam Physician. June 2001. Vol.30. No.6. p.551-5.
Reviewed by Dr Barry Suckling
Review: Much debate still abounds. However, there are many tips in this article. Children under 12 months are at higher risk of vesico-ureteric reflux (VUR) and renal damage. Family history of reflux may be relevant in any child who is unwell. Urine collection method is very important. Predisposing factors like VUR, cleaning of the perineum and constipation need attention to prevent recurrent UTI.

Physiology

22-150 Vessels of death or life.

Jain RK, Carmeliet PF. Sci Am. December 2001. Vol.285. No.6. p.26-33.
Reviewed by Dr Ron Vautier

Review: Research to identify the factors which promote or inhibit angiogenesis has led to trials of about 20 compounds which interfere with these processess. Hence there may be coming along new therapies for cancer, retinal disease, atherosclerosis, endometriosis, obesity, heart attacks, other thromboses, fractures, neurodegenerative conditions, and baldness.
Comment: This is a relatively quick and easy read to introduce an area few of us will be familiar with (yet?).

Preventive Medicine and Screening

22-151 Screening for ovarian cancer.

Review: Ovarian cancer is the leading cause of death from gynaecological malignancy. Although a screening test would be attractive, none is available. Screening for ovarian cancer in the general population is not recommended. However screening for ovarian cancer in women at high risk may be worthwhile with transvaginal ultrasound and Ca125. Those at high risk are those with a family history of ovarian or breast cancer. Three large trials of general population screening are under way.

22-152 Is a Pap smear enough?

Heley S. Aust Fam Physician. June 2001. Vol.30. No.6. p.535-8.
Reviewed by Dr Barry Suckling
Review: New technologies, including computer monitored microscope, fluid based cytology and HPV, DNA testing are now available, in addition to the Pap smear.
Comment: Should they be offered? No. Adding them would increase the detection rate from 1% of all smears tested to 1.05% at an annual cost of $30 million in Victoria alone. The main aim should still be recruitment and good Pap smear technique.

22-153 Bowel cancer.

Semmens JB, Platell C. Aust Fam Physician. June 2001. Vol.30. No.6. p.539-45.
Reviewed by Dr Barry Suckling
Review: A major cause of death in those over 50 years. Half the patients diagnosed will be dead in five years. Survival is more dependent on the stage of the disease at diagnosis, than anything else. Unfortunately, screening of the general population by FOB, sigmoidoscopy or colonoscopy have as many drawbacks as benefits.
Comment: At present screening high risk patients with colonoscopy is the best investment of funds.

22-154 Historical overview of vaccines.

Silvers MJ, Steptoe MM. Prim Care. December 2001. Vol.28. No.4. p.685-95.
Reviewed by Dr M Hewitt
Review: A wonderful review of the significant advances vaccination has offered for the health of humanity. Excellent research and scholarship. A medical history from Jenner and Pasteur through to Sabin and Salk that reads like a history of medicine.
Comment: Excellent.

22-155 Routine childhood immunizations.

Campbell AL, Bryant KA. Prim Care. December 2001. Vol.28. No.4. p.713-38.
Reviewed by Dr M Hewitt
Review: A careful review of all the recommended routine vaccinations of children, including rare anticipated adverse reactions.
Comment: A good commentary on the usefulness to public health that immunisations have given.

22-156 Combination vaccines.

Decker MD. Prim Care. December 2001. Vol.28. No.4. p.739-61.
Reviewed by Dr M Hewitt
Review: A brief history of the development of combinations of related and unrelated antigens for use in a multiple vaccine. The various combinations currently in use are described along with features of clinical testing and safety concerns.
Comment: With many preventable diseases these combination vaccines are convenient, effective and safe.

22-157 Adult vaccinations.

Zimmerman RK, Ball JA. Prim Care. December 2001. Vol.28. No.4. p.763-90.
Reviewed by Dr M Hewitt
Review: Discussion involving influenza, pneumococcal and tetanus-diphtheria vaccines for adults and the public health benefits for their use. There is a list of various occupations with the entailed risks of exposure to antigens and the recommended vaccinations to be given.
Comment: Good value. Especially rabies for spelunkers.

22-158 Maternal vaccines.

Glezen WP. Prim Care. December 2001. Vol.28. No.4. p.791-806.
Reviewed by Dr M Hewitt
Review: The article discusses the rationale for consideration of alternative strategies for the use of new vaccines. The idea that immunising a pregnant women may provide protection for both mother and baby at a vulnerable time in their lives is discussed (e.g. tetanus toxoid and inactivated influenza).
Comment: Consideration for RSV, prevention of Group B streptococcal disease and pneumococci is involved.

22-159 Vaccines, biological warfare, and bioterrorism.

Polgreen PM, Helms C. Prim Care. December 2001. Vol.28. No.4. p.807-21.
Reviewed by Dr M Hewitt
Review: Current concerns about biological warfare and agents likely to be used are addressed. Chief concern being plague, smallpox, anthrax and botulinum toxin.
Comment: Evidence from defectors indicate that Iraq and Russia have massive stockpiles of such material and the necessary preparation for use in a hostile situation.

22-160 Vaccines for international travel.

McKinney WP. Prim Care. December 2001. Vol.28. No.4. p.823-52.
Reviewed by Dr M Hewitt
Review: A comprehensive coverage of the necessary risks modern travellers to exotic locations face and how vaccination can reduce the risk of health problems.
Comment: Good update.

22-161 Challenges to vaccine safety.

Marshall GS, Gellin BG. Prim Care. December 2001. Vol.28. No.4. p.853-68.

Reviewed by Dr M Hewitt

Review: Discussion regarding the issues and concerns physicians have to address with an informed public. Occasionally inappropriate anxiety and opposition to vaccination leads to reduced coverage. The article addresses a reply to some of those concerns.

Comment: The benefits far outweigh the risks, although the risks are real and merit being addressed by doctors when questioned by concerned, anxious people.

Psychiatry and Psychology

22-162 Is St. John's wort an effective treatment for major depression?

Tatum P, Lindbloom EJ. J Fam Pract. July 2001. Vol.50. No.7. p.624.

Reviewed by Dr Bruce Adlam

Review: A meta-analysis of 23 randomised trials published in 1996 found St John's wort (SJW) to be effective for treating depressive disorders. However, the trials have been criticised for such flaws as lack of standard diagnostic criteria, short duration, wide dose variation, failure to blind, lack of placebo use, and suboptimal doses of comparison antidepressants. This well-designed study addresses these concerns and did not find a significant benefit of SJW in the treatment of major depression. (Original article reviewed: JAMA 2001; 285: 19978-86).

Comment: The study did not address treatment of dysthymia or minor depression. Patients treated with SJW did not respond better than those taking placebo. Although remission rates were significantly better than those in the placebo group, these rates were very low for both groups. Given the seriousness of major depression and the availability of effective alternatives, SJW should not be used as first-line therapy for major depression.

22-163 Standardized mini-mental state examination: Use and interpretation.

Vertesi A, Lever JA, Molloy DW, et al. Can Fam Physician Med Fam Can. October 2001. Vol.47. p.2018-23.

Reviewed by Dr Mike Lyons

Review: 'The Mini-Mental State Examination (MMSE) is a valid and reliable instrument widely used to screen for cognitive impairment in older adults'. Explicit guidelines have been added on administration and scoring and the authors strongly advise following the guidelines to ensure reliability. Tables equate scores with functional impairment in daily activities. Alzheimer's disease, vascular dementia, dementia with Lewy bodies and depression are highlighted. Limitations of the MMSE are noted.

Comment: The MMSE itself is not outlined. References are given to the original 1975 Folstein article. References are also included for the guidelines and video issued by one of the authors (Molloy). A postal address and purchase price for the SMMSE booklet or Users Guide is given.

Research Design and Methodology

22-164 Relationships between authors of clinical practice guidelines and the pharmaceutical industry.

Choudhry NK, Stelfox HT, Detsky AS. JAMA. 6 February 2002. Vol.287. No.5. p.612-7.

Reviewed by Dr Len Brake

Review: Potential conflicts may arise where authors of the trendy CPGs (Clinical Practice Guidelines) have 'contact' with the pharmaceutical industry. A survey was made of 192 guideline authors. Eighty-seven per cent had some contact with the pharmaceutical industry but just 7% suggested that this had any effect on their guideline advice. The question of specific declarations regarding financial interactions with drug companies on the actual guidelines is raised.

Smoking

22-165 Reveiw: various interventions increase smoking cessation rates.

Luckmann R. Evidence-Based Medicine. March-April 2001. Vol.6. No.2. p.43.

Reviewed by Dr Bruce Arroll

Review: This is a publication of a Cochrane review of techniques of smoking cessation. All nicotine replacements are effective while anxiolytic drugs are not helpful. The antidepressant drugs Bupropion and Nortriptyline increased stopping rates. Clonidine is effective but limited by its side-effect profile. Acupuncture, hypnosis and exercise showed limited evidence of effectiveness. (Original article reviewed: BMJ 2000 Aug 5; 321: 355-8).

Comment: National advice seems to favour nicotine initially but antidepressants are next. The fact that Nortriptyline is subsidised gives it an advantage over Buproprion.

Sports and Sports Medicine

22-166 Psychiatric conditions in sports: diagnosis, treatment, and quality of life.

Glick ID, Horsfall JL. Physician and Sportsmedicine. August 2001. Vol.29. No.8. p.45-55.

Reviewed by Dr Rob Campbell

Review: Athletes suffer the same psychiatric illnesses as the non-active population. The increase in professional sport in NZ with its associated stress for players and coaches may expose more players to high risk situations.

Comment: Some important issues for GPs and team doctors in the management of the athletes are explored. Very helpful.

Urology

22-167 Is extended-release oxybutynin (Ditropan XL) or

tolterodine (Detrol) more effective in the treatment of an overactive bladder?

Hartnett NM, Saver BG. J Fam Pract. July 2001. Vol.50. No.7. p.571.

Reviewed by Dr Bruce Adlam

Review: This study compares the efficacy and tolerability of the newly developed extended-release oxybutynin with tolterodine. Oxybutynin and tolterodine both produce a marked decrease in symptoms in patients with an overactive bladder. These medications have a similar cost (in the USA) and side effect profile, but extended-release oxybutynin is modestly more effective than tolterodine. (Original article reviewed: Mayo Clin Proc 2001; 76: 358-63).

Comment: Note the combination of anticholinergic medication and behavioral therapy provides an even greater benefit than pharmacotherapy alone.

Virus Diseases

22-168 Frequency of attendance in general practice and symptoms before development of chronic fatigue syndrome: a case-control study.

Hamilton WT, Hall GH, Round AP. Br J Gen Pract. July 2001. Vol.51. No.468. p.553-8.

Reviewed by Dr Rob Henderson

Review: The study compared the behaviour, before diagnosis, of 49 patients with chronic fatigue syndrome and 37 patients with multiple sclerosis. The attendance behaviour of both groups was examined for the fifteen years before they were diagnosed with the condition. The chronic fatigue syndrome patients were found to consult their GP's more frequently in the fifteen years before the development of their condition for a wide variety of complaints. The authors suggest that behavioural factors have a role to play in the aetiology of chronic fatigue syndrome.

Comment: This is an excellent study and makes fascinating reading.