Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Ann Emerg Med*
Ann Intern Med*
Aust Fam Physician*
BMJ*
Br J Sports Med*
Homeopathy*
Intern Med J*
J Fam Pract*
JAMA*
Lancet*
N Engl J Med*
Physician and Sportsmedicine*
Postgrad Med*
Sci Am*
Venereology
*Journals indexed in Medline

Alcohol and Substance Abuse

23-077 Carbamazepine effective for alcohol withdrawal.

See S. J Fam Pract. September 2002. Vol.51. No.9. p.778.
Reviewed by Dr Bruce Adlam

Review: Outpatient management of acute alcohol withdrawal often includes a tapering dose of a benzodiazepine e.g. lorazepam. Both lorazepam and carbemazepine are equally effective. Of the patients who reported multiple detoxifications those receiving carbemazepine drank less than the lorazepam treated group (RCT n= 136 p=.004) making it a suitable alternative. Overall frequency of side effects were the same but clinicians reported higher frequency of dizziness and uncoordination in the lorazepam treated group. (Original article reviewed: J Gen Intern Med 2002; 17: 349-55)

Asthma

23-078 Is there a role for theophylline in treating patients with asthma?

Fotinos C, Dodson S. J Fam Pract. September 2002. Vol.51. No.9. p.744.
Reviewed by Dr Bruce Adlam

Review: Evidence based answer. Theophylline has a limited role as maintenance therapy. It may help lower the dosage of inhaled steroids needed to control chronic asthma but offers no benefit for acute asthma exacerbations over corticosteroids and beta agonists. For children intravenous aminophylline may improve the clinical course of severe asthma though side effects and toxicity may limit use in most settings (Grade of recommendation: A, based on systematic reviews and RCTs).

23-079 Inhaled fluticasone superior to montelukast in persistent asthma.

Satre TJ. J Fam Pract. September 2002. Vol.51. No.9. p.780.
Reviewed by Dr Bruce Adlam

Review: Significantly changed FEV1 in fluticasone group –22% compared with 14% montelukast, confirming earlier studies indicating that inhaled steroids should be first line treatment. (Original article reviewed: Mayo Clin Proc 2002; 77: 437-45)

Cardiovascular System

23-080 Prevention of myocardial infarction.

Adams MR. Intern Med J. December 2002. Vol.32. No.12. p.595-600.
Reviewed by Dr Helen Moriarty

Review: The new knowledge in this area has come from an understanding of vessel wall inflammation in atherosclerosis. In addition to the well established risk factors, new risks for premature coronary disease have come to light. Elevated homocysteine is one - reversed by folic acid supplements. Detection by imaging and serum markers are discussed as well as risk management techniques.
Comment: A good up to date review article focusing on primary prevention.

23-081 Presenting complaint among patients with myocardial infarction who present to an urban, public hospital emergency department.

Gupta M, Tabas JA, Kohn MA. Ann Emerg Med. August 2002. Vol.40. No.2. p.180-6.
Reviewed by Dr Mike Slatter
Review: This is a retrospective cross-sectional study to determine the frequency of presenting complaint in patients who were admitted with acute myocardial infarction (AMI). Results showed 53% presenting with chest pain, 17% with shortness of breath, 7% with cardiac arrest, 4% with dizziness/syncope/weakness, 2% with abdominal pain and 17% with other symptoms.
Comment: Good study showing the need for heightened awareness of atypical presentations of AMI. These patients are at increased risk for delayed diagnosis, less aggressive treatment and increased hospital mortality. We need to broaden our triage criteria for urgent ECG if we are to hasten the diagnosis in these patients.

23-082 Exercise and coronary artery disease: Assessing causes and managing risks.

Libonati JR, Glassberg HL. Physician and Sportsmedicine. November 2002. Vol.30. No.11. p.23-9.
Reviewed by Dr Rob Campbell
Review: The risks and rewards of exercise are explored in this paper. Excellent detailed explanations of the pathology and vascular reactions to exercise are included.
Comment: An excellent indepth review which should give you confidence to prescribe exercise in your cardiac patients.

23-083 Major outcomes in high-risk hypertensive patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic: The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT)

The ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group. JAMA. 18 December 2002. Vol.288. No.23. p.2981-97.
Reviewed by Dr Raina Elley
Review: The use of thiazide-type diuretics (chlorthalidone) for the treatment of hypertension appeared to reduce the rate of combined cardiovascular events, stroke and heart failure, compared with ACE inhibitor treatment (lisinopril), according to this study. There were also higher rates of heart failure in the calcium channel blocker (amlodipine) group compared with the thiazide-like diuretic group. However, there were no significant differences in the primary outcomes (combined fatal CHD and non-fatal MI) between the three groups. Results were consistent for most subgroup analyses except for stroke and heart failure amongst Blacks, where much of the benefit of chlorthalidone over lisinopril was seen. Similar blood pressure reduction was achieved with both agents. This was a double-blind randomised controlled trial. The study included 33 357 hypertensive >55 year-old subjects with at least one cardiovascular risk factor, enrolled from 623 North American centres. Median follow-up was 4.9 years. The allocated step one drug regime, or equivalent, was adhered to in about 80% of subjects at the end of the study and about two thirds were on multiple antihypertensive medications. Thiazide-like diuretics are therefore recommended as first line antihypertensive treatment because they are at least as effective as more expensive medications. This strategy has the potential to make huge savings in annual drug expenditure. (See also 23-084 and 23-085)
Comment: This trial is double-blind and much larger than the NEJM trial by Wing et al. (see 23-087), with very different results. Perhaps this shows the importance of double-blinding trials to reduce bias.

23-084 Major outcomes in moderately hypercholesterolemic, hypertensive patients randomized to pravastatin vs usual care: The Antihypertensive and Lipd-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT - LLT)

The ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group. JAMA. 18 December 2002. Vol.288. No.23. p.2998-3007.
Reviewed by Dr Raina Elley
Review: See 23-083.

23-085 The verdict from ALLHAT - Thiazide diuretics are the preferred initial therapy for hypertension.
Appel LJ. JAMA. 18 December 2002. Vol.288. No.23. p.3039-42.
Reviewed by Dr Raina Elley
Review: See 23-083.

23-086 Multifactorial intervention and cardiovascular disease in patients with type 2 diabetes.
Gaede P, Vedel P, Larsen N, et al. N Engl J Med. 30 January 2003. Vol.348. No.5. p.383-93.
Reviewed by Dr Raina Elley
Review: Intensive treatment involving behaviour modification for diet, smoking and exercise, and targeted pharmacological treatment, reduced cardiovascular and microvascular events by 50 per cent over an eight-year follow-up. (Absolute 20% reduction in risk of cardiovascular events, which is higher than studies of single-factor intervention strategies aimed at hyperglycaemia, hypertension or dyslipidaemia.) The control group received 'usual care'. In the intensive group, ACE inhibitors (equivalent to 50mg captopril bd or 50mg Losarten bd) were prescribed irrespective of blood pressure. Targets for this group included a BP of <130/80, HbA1c<6.5, tight control of lipids with statins and fibrates, and all were given low dose aspirin (unless contraindicated).
Comment: It seems that even lower blood pressure, glycaemic, and lipid targets need to be set for our patients with diabetes.

23-087 A comparison of outcomes with angiotensin-converting-enzyme inhibitors and diuretics for hypertension in the elderly.
Wing LM, Reid CM, Ryan P, et al. N Engl J Med. 13 February 2003. Vol.348. No.7. p.583-92.
Reviewed by Dr Raina Elley
Review: According to this study the use of ACE inhibitors for the treatment of hypertension in the elderly appeared to reduce the rate of non-fatal cardiovascular events and myocardial infarctions compared with diuretic treatment. However, there were similar rates of stroke for both groups. Similar blood pressure reduction was achieved with both agents. This was an open-label randomised controlled trial, although assessors were blinded. The study included 6 083 hypertensive 65–84 year-old subjects enrolled from 1 594 Australian general practices. Median follow-up was 4.1 years. The allocated drug regime was adhered to in about 60% of subjects at the end of the study and about one third were on multiple antihypertensive medications. Interestingly, when a post-hoc analysis was done by gender, the benefit remained for males but there was no benefit for female subjects (Hazard ratio was 1.00).
Comment: Compare this to the ALLHAT study review (see 23-083). Who are you going to believe?

23-088 When should patients with asymptomatic aortic stenosis be evaluated for valve replacement?
Colen M, Lindbloom EJ, Meadows S. J Fam Pract. September 2002. Vol.51. No.9. p.739.
Reviewed by Dr Bruce Adlam
Review: Evidence based answer. American College of Cardiology/ American Heart Association recommendation is five yearly ECHO for mild, two yearly for moderate and annually for severe. This is based on a prospective study that found the severity of stenosis at baseline to be the strongest prognostic predictor. Patients with jet velocity of <3.0 m/s were unlikely to develop symptoms within five years, those with jet velocity >4 m had a 50% likelihood of developing symptoms or dying within two years.
Comment: In summary, markers of worse prognosis were (1) moderate to severe calcification, (2) greater than 4 m/sec jet velocity (3) rate of progression greater than 3 m/sec annually, (4) decreasing functional status.

23-089 Cost effectiveness of aspirin vs clopidogrel for secondary prevention of coronary heart disease.
Lindbloom EJ, Eaton LJ. J Fam Pract. September 2002. Vol.51. No.9. p.789.
Reviewed by Dr Bruce Adlam
Review: A computer simulation using the Coronary Heart Disease Policy model from societal viewpoint suggests that clopidogrel at its current price has acceptable* cost effectiveness when used by aspirin intolerant** patients with cardiovascular disease (aspirin $US11 000 / QALY and clopidogrel given to 5.7% of those intolerant of aspirin $US 31 000 / QALY). Note cost. (* acceptable cost effectiveness has not been defined but in US pressure exists for this to be in the vicinity of $US50 000/ QALY; ** intolerance is not defined in this report.) (Original article reviewed: N Eng J Med 2002; 346: 1800-6)
Comment: Accept this with caution. The authors made an assumption that the price of lopidogrel would drop by 70% over time to bring it under the 50k threshold. Clopidogrel alone for all has a cost effectiveness of $250 000/ QALY.

23-090 Homocysteine and cardiovascular disease: evidence on causality from a meta-analysis.
Wald DS, Law M, Morris JK. BMJ. 23 November 2002. Vol.325. No.7374. p.1202-8.
Reviewed by Dr Len Brake
Review: The evidence that a raised serum homocysteine is a cause of cardiovascular disease is strengthened. Ninety-two studies were analysed looking at both the link between homo-

cysteine levels and heart disease and stroke as well as the risk reduction.
Comment: On the basis of this paper, a decrease in serum homocysteine of 3umol/l (achievable by daily intake of 0.8mg folic acid) should reduce the risk of ischaemic heart disease by 16%, deep vein thrombosis by 25% and stroke by 24%.

Cerebrovascular System

23-091 Alcohol consumption and risk of stroke: A meta-analysis.

Reynolds K, Lewis LB, Nolen JD, et al. JAMA. 5 February 2003. Vol.289. No.5. p.579-88.
Reviewed by Dr Raina Elley
Review: This meta-analysis of 35 observational studies found that drinking more than five drinks of alcohol per day (60g of alcohol) was associated with an 1.64 relative risk increase of stroke when compared with abstainers (95% CI 1.39-1.93). Drinking an average of less than one drink per day (12 g of alcohol) may be protective, as the relative risk was 0.83, (95% CI 0.75-0.91). The mechanism of action for increased haemorrhagic stroke is likely to be due to alcohol-induced hypertension and clotting disorders. Moderate alcohol may reduce the risk of ischaemic stroke by increasing HDL and decreasing platelet and fibrinolytic activity.
Comment: Be cautious if you are considering advising patients to drink moderate amounts of alcohol to prevent stroke. Although most studies controlled for confounding factors such as age and traditional cardiovascular risk factors, there is always the possibility of other confounding factors being involved, such as 'abstainers' including previous high alcohol drinkers, or psychological features associated with not-drinking. We will probably never know for sure, as randomised controlled trials are unlikely because of the ethical implications.

Contraception and Family Planning

23-092 Vasectomy not a risk factor for prostate cancer.

Staryer SM. J Fam Pract. September 2002. Vol.51. No.9. p.791.
Reviewed by Dr Bruce Adlam
Review: Reassuring words indicating that having a vasectomy does not increase a man's risk of developing prostate cancer even after 25 or more years. Conflicting results of several case-controlled and cohort studies have been laid to rest by a systematic review published in JAMA which also suggests several possible mechanisms for the inconclusive results. (Original article reviewed: JAMA 2002; 287: 3110-5)

Diagnosis

23-093 Assessment of the dizzy patient.

Byrne M. Aust Fam Physician. August 2002. Vol.31. No.8. p.722-7.
Reviewed by Dr Barry Suckling
Review: Provides a framework for the assessment of the patient with dizzyness. The framework provides a systematic means of obtaining a diagnosis and management plan.

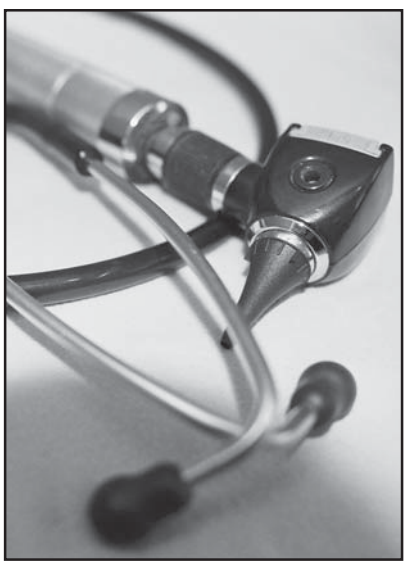

Photo: Michael Long

Ear, Nose and Throat

23-094 Childhood ENT disorders: When to refer to specialists.

Harris C. Aust Fam Physician. August 2002. Vol.31. No.8. p.701-4, 716.
Reviewed by Dr Barry Suckling
Review: Reviews the natural history of common ENT conditions and the effectiveness (or ineffectiveness) of surgical intervention.
Comment: The article could have been titled 'when not to refer'. The common ENT conditions are discussed.

23-095 A hole in the drum: An overview of tympanic membrane perforations.

Fagan P, Patel N. Aust Fam Physician. August 2002. Vol.31. No.8. p.707-10.
Reviewed by Dr Barry Suckling
Review: Differentiates between safe and unsafe perforations. Acute perforations are usually safe and heal spontaneously. Chronic perforations are either safe or unsafe, depending on the risk of complications. Unsafe perforations are often associated with cholesteatoma (an epidermoid cyst of the middle ear and mastoid). It causes bone destruction and causes ear and intracranial complications.

23-096 Tinnitus: More can be done than most GPs think.

Tonkin J. Aust Fam Physician. August 2002. Vol.31. No.8. p.712-6.
Reviewed by Dr Barry Suckling
Review: Outlines the diagnostic features of tinnitus to determine causes and aggravators. It provides an overview of treatment.

23-097 Management of epistaxis in general practice.

Pashen D, Stevens M. Aust Fam Physician. August 2002. Vol.31. No.8. p.717-21.
Reviewed by Dr Barry Suckling
Review: The majority originate from Little's area. Silver nitrate and electrocautery can be given with minimal discomfort and cost in general practice. Adequate preparation and

appropriate equipment are discussed. Nasal packing is appropriate for posterior and repeated epistaxis. Adequate analgesia is essential. Packing can be performed in general practice with appropriate equipment.

Emergency Medicine

23-098 On the front lines: Family physicians' preparedness for bioterrorism.

Chen FM, Hickner J, Fink KS, et al. J Fam Pract. September 2002. Vol.51. No.9. p.745-50.
Reviewed by Dr Bruce Adlam
Review: A quarter of US family physicians believe they are prepared to respond, those with training are obviously more confident. Physicians likely to be on the front line (potentially everybody?) in a bio-terrorism attack should seek training in detection, surveillance and response.
Comment: Good topic for peer groups if not already discussed.

Endocrinology

23-099 Oral hypoglycaemics: When not to use what.

Phillips P, Braddon J. Aust Fam Physician. July 2002. Vol.31. No.7. p.637-43.
Reviewed by Dr Barry Suckling
Review: This article focuses on those patients where particular hypoglycaemic agents should not be used. Practical cases are used for illustration.

23-100 Acarbose delays onset of type 2 diabetes mellitus.

Gazewood J. J Fam Pract. September 2002. Vol.51. No.9. p.784.
Reviewed by Dr Bruce Adlam
Review: This is based on the assumption that patients who develop type 2 diabetes initially pass through an impaired glucose tolerance phase and that therapies that reduce resistance to insulin or protect B cells could prevent or delay progression to diabetes. (Original article reviewed: Lancet 2002; 359: 2072-7)
Comment: Delays of at least 3.3 years are reported from this large multi country study but it is unclear whether ascarbose delays or prevents diabetes or whether morbidity and mortality are altered. One third of patients are intolerant of the medication. Lifestyle modification of diet and physical activity remain first line treatment.

Eye Diseases

23-101 Management of corneal abrasion in children: A randomised clinical trial.

Michael JG, Hug D, Dowd MD. Ann Emerg Med. July 2002. Vol.40. No.1. p.67-72.
Reviewed by Dr Mike Slatter
Review: This is a study on a randomised clinical trial looking at eye patching for corneal abrasion in the age group three to 17 yrs. The recommended therapy has been eye patching, cycloplegic drops and antibiotics. This study suggests that eye patching for corneal abrasions in children makes no difference to the rate of healing.
Comment: Studies in adults have shown similar results. It is probably time to abandon patching given these findings and probable non-compliance with patches, especially in children.

23-102 Incidence of sight-threatening retinopathy in patients with type 2 diabetes in the Liverpool Diabetic Eye Study: a cohort study.

Younis N, Broadbent DM, Vora JP, et al. Lancet. 18 January 2003. Vol.361. No.9353. p.195-200.
Reviewed by Dr Tony Hanne
Review: Over 20 000 patients from 101 general practices in the UK were screened annually for diabetic eye disease with the purpose of establishing the most appropriate surveillance programme. The likelihood of significant findings in the first year was very low but rose steeply with time and the observation of pre-proliferative disease. The recommendation was made that screening after the initial baseline observation should be infrequent at first then more frequent with time and disease progression. (see also 23-103)
Comment: While the argument made is a strong one from a cost-benefit point of view, the devastating effect of blindness still gives support for annual screening. The experience of most of us in general practice is that it is easier to establish people in a yearly routine from the start.

23-103 Screening interval for retinopathy in type 2 diabetes.

Klein R. Lancet. 18 January 2003. Vol.361. No.9353. p.190-1.
Reviewed by Dr Tony Hanne
Review: See 23-102.

Gastroenterology

23-104 Irritable bowel syndrome: Diagnosis is based on clinical criteria.

Morgan T, Robson KM. Postgrad Med. November 2002. Vol.112. No.5. p.30-41.
Reviewed by Dr Chris Milne
Review: Irritable bowel syndrome is a heterogeneous disorder. In the absence of alarm symptoms (fever, weight loss, or GI bleeding) a limited workup is needed. Treatment involves dietary modification and symptom control via specific medication. Antispasmodics are the first line of treatment for pain, and loperamide is the first choice agent for diarrhoea. Fibre and bulking agents are recommended for constipation. Avoid stimulant laxatives.
Comment: One of the best models of the gut is that of a slot machine and conveyor belt. This was taught to me on a sports medicine course in London many years ago. It helps explain virtually all symptoms relating to the tubular gut, and is easily understood by patients.

23-105 Recent developments in gastroenterology.

Moayyedi P, Ford A. BMJ. 14 December 2002. Vol.325. No.7377. p.1399-402.
Reviewed by Dr Len Brake
Review: Gastroenterologists used to be the poor cousins amongst the specialist group. Then, like mana from the sky came endoscopy. Now their earnings are up there with wealthy surgical specialists. It is rumoured that an Auckland gastroenterologist is to purchase his own helicopter – God bless the gastroscope. But be that as it may.
Comment: This article in the Clinical Review series is superb and includes updates in screening and treatment, making it an excellent investment of reading time.

Gynaecology

23-106 HRT advice: Information for specific scenarios.

The Royal Australian College of General Practitioners. Aust Fam Physician. August 2002. Vol.31. No.8. p.733-5.
Reviewed by Dr Barry Suckling
Review: Exactly as the title says. An excellent practical, brief summary of HRT use in the different specific groups of women.
Comment: The best brief summary I have seen.

Health Services

23-107 Vascular health risks in the Aboriginal community: A cultural approach.

Abbott P, Close G. Aust Fam Physician. July 2002. Vol.31. No.7. p.605-10.
Reviewed by Dr Barry Suckling
Review: Vascular disease is responsible for a high proportion of the early death and chronic disease suffered by Aboriginal people. There are historical, socio-economic, cultural, environmental and genetic factors.
Comment: The most successful interventions are culturally appropriate self-management programmes developed and implemented with Aboriginal community control.

23-108 A role worthy of support: The general practitioner in Aboriginal and Torres Strait Islander health.

Reath J, Curtis P, Death E. Aust Fam Physician. July 2002. Vol.31. No.7. p.611-5.
Reviewed by Dr Barry Suckling
Review: Aboriginal and Torres Strait Islander health is a national health priority in Australia. GPs working in these communities require ongoing support and training.
Comment: A wide range of support and training strategies has been implemented and these are described.

23-109 Lessons from East Arnhem land: Improving adherence to chronic disease treatments.

Bryce S. Aust Fam Physician. July 2002. Vol.31. No.7. p.617-21.
Reviewed by Dr Barry Suckling
Review: Adherence (or compliance) to medical therapy is poor in indigenous Australian communities. This paper describes approaches and techniques to improve adherence.
Comment: Gaining trust and credibility is important and approaches to gain that trust are described. Overcoming the language and world view barriers that prevent good communication is critical and ways of overcoming these are described.

23-110 Team approach versus ad hoc health services for young people with physical disabilities: a retrospective cohort study.

Bent N, Tennant A, Swift T, et al. Lancet. 26 October 2002. Vol.360. No.9342. p.1280-6.
Reviewed by Dr Tony Hanne
Review: In a few areas of the UK support services for physically disabled young people have been organised on a multi-disciplinary basis rather than the usual uncoordinated expectation that the disabled will fit into the health system. This qualitative study was to find out whether this approach was worthwhile. The results are striking. The team approach increased the likelihood that disabled young people would participate in

society by about 2.5 times. The contact time with team members including GPs was no different from the usual system and the cost was no greater.
Comment: Just how GPs were included in the team approach is not explained in the article and would be of interest. The conclusion that a team functions better for the patient comes as no surprise and would almost certainly be true of many other areas of medical care. The problem is in the lack of team players – starting in general practice.

Homeopathy

23-111 A survey of the use of over-the-counter homeopathic medicines purchased in health stores in central Manchester.

Reid S. Homeopathy. October 2002. Vol.91. No.4. p.225-9.
Reviewed by Dr Mimi Irwin
Review: Over the counter homeopathy is a popular form of treatment. The purpose of this study was to find out what conditions were being treated, perceived effectiveness, how long OTC homeopathy had been used, reasons for using it and whether patients combined homeopathy with pharmaceutical agents. Seventy-five questionnaires were analysed.
Comment: Patients chose OTC homeopathy to treat respiratory, mental/psychological and bruise/injuries. They perceived it to be safe and effective. Thirteen per cent combined homeopathy with their conventional pharmaceutical treatment. It would be interesting to see if similar trends exist in NZ.

23-112 The toxicology of Amanita phalloides.

Bonnet MS, Basson PW. October 2002. Vol.91. No.4. p.249-54.
Reviewed by Dr Mimi Irwin
Review: Amanita phalloides otherwise known as death cap is a member of the Kingdom Fungi. This article describes its appearance, history and debunks common myths on how to render this noxious mushroom safe. There is a full description of its toxic effects.
Comment: Amanita phalloides is the most common cause of mushroom poisoning in man. It can be found growing in NZ under oak trees. It causes disorientation, coma and gastrointestinal symptoms and death can occur due to hepatic failure a week after ingestion. This article is of interest to those practising homeopathy and others curious about toxicology.

23-113 Molluscum contagiosum: a case series.

Rajendran ES. Homeopathy. October 2002. Vol.91. No.4. p.255-9.
Reviewed by Dr Mimi Irwin
Review: The author reports on a series of 30 patients who presented with Molluscum contagiosum. Of the series, 15 completely recovered and 12 improved. The fully recovered cases are presented in some detail, these patients presented early in the course of the infection and were fully recovered in two to three months. The remedies found most useful were: Natrum sulphuricum, sulphur and Natrum muriaticum. Molluscum contagiosum is a self limiting benign disease.
Comment: It was not always clear to me why particular remedies were chosen nor the reason for choosing to treat with high potencies – 10 M. This paper will be of interest to GPs practising homeopathy.

Immunology and Allergy

23-114 The long arm of the immune system.

Banchereau J. Sci Am. November 2002. Vol.287. No.5. p.52-9.
Reviewed by Dr Ron Vautier
Review: Dendritic cells are white blood cells which come to reside in the skin, mucous membranes, and organs such as the lungs and spleen. They are highly tuned to capture and process antigens in ways which turn on other arms of the immune system. New understanding of their function is producing new vaccines, particularly for cancer.
Comment: This is definitely a good read if you wish to advance your understanding of immunology.

Law and Medicine

23-115 Failure to diagnose breast cancer.

Bird S. Aust Fam Physician. July 2002. Vol.31. No.7. p.623-5.
Reviewed by Dr Barry Suckling
Review: Failure to diagnose cancer is a common cause of medical negligence claims against GPs. Most of these are patients under 40 who are diagnosed with breast cancer. The most common causes of failure are: (1) The physical findings do not appear suspicious. (2) Failure of the GP to follow up the patient.
Comment: This article outlines risk management strategies for GPs.

23-116 Medication errors: Iron injections.

Bird S. Aust Fam Physician. August 2002. Vol.31. No.8. p.759-60.
Reviewed by Dr Barry Suckling
Review: Despite their low frequency of use, intramuscular iron injections account for one fifth of claims against GPs involving medication errors.
Comment: This article outlines steps to minimise risk.

Metabolic Diseases

23-117 Haemochromatosis and family testing: What should a GP do?

Newstead J, Delatycki M, Aitken MA. Aust Fam Physician. June 2002. Vol.31. No.6. p.533-7.
Reviewed by Dr Barry Suckling
Review: As awareness about haemochromatosis increases in the community, GPs are encountering more requests for information about screening family members.
Comment: This article uses case histories to discuss which family members should be tested, how they

Photo: Michael Long

should be tested, and how to interpret the results of iron studies and the HFE gene test.

Musculoskeletal System

23-118 Sacroiliac joint pain syndrome in active patients: A look behind the pain.

Chen YC, Fredericson M, Smuck M. Physician and Sportsmedicine. November 2002. Vol.30. No.11. p.30-7.
Reviewed by Dr Rob Campbell

Review: A review of the biomechanics, assessment and treatment options of sacroiliac joint problems. Good description of examination techniques and treatment options.
Comment: A very helpful review of this difficult joint. If you are not diagnosing sacroiliac joint problems then read this.

Neurology

23-119 The enigma of Huntington's Disease.

Cattaneo E, Rigamonti D, Zuccato C. Sci Am. Decmber 2002. Vol.287. No.6. p.92-7.
Reviewed by Dr Ron Vautier

Review: Degeneration of neurons in a region of the basal ganglia somehow arises because a defective gene produces a protein which has a large polyglutamine region. A number of molecular mechanisms appear to play significant roles in what is turning out to be a biochemically complex disorder.
Comment: This may well be intrinsically interesting for some, and a useful review of some basic ideas in biochemistry for others.

23-120 The many causes of headache: Migraine, vascular, drug-induced, and more.

Levin M. Postgrad Med. December 2002. Vol.112. No.6. p.67-82.
Reviewed by Dr Chris Milne

Review: Headache is one of the commonest presenting symptoms in general practice. Having a diagnostic system to identify its likely cause is therefore essential. This article gives a clear summary of most types of headache seen in clinical practice, table 3 listing the distinguishing features for 13 different causes is excellent.
Comment: For the GP registrar, or the experienced clinician who wants a refresher, this article is outstanding.

23-121 Clinical policy: Neuroimaging and decisionmaking in adult mild traumatic brain injury in the acute setting.

Jagoda AS, Cantrill SV, Wears RL, et al. Ann Emerg Med. August 2002. Vol.40. No.2. p.231-49.
Reviewed by Dr Mike Slatter

Review: This is a Clinical Policy document which has been adopted by the American College of Emergency Physicians (ACEP). It discusses the concept of Mild Traumatic Brain Injury (MTBI), its definition and aspects of management. Three critical questions are asked regarding skull x-rays, indication for CT scan and when patients can safely be discharged home. Clear recommendations are made regarding these crucial issues.
Comment: This is an excellent article which clarifies management in those patients we commonly see with mild head injury. Certain patients should be considered for an urgent head CT scan. Skull x-rays are not recommended in the evaluation of MTBI.

23-122 Does the patient have Parkinson Disease?

Rao G, Fisch L, Srinivasan S, et al. JAMA. 15 January 2003. Vol.289. No.3. p.347-53.
Reviewed by Dr Raina Elley

Review: Misdiagnosis of Parkinson Disease (PD) is associated with adverse effects or delays in treatment. However, no lab tests or imaging tests are helpful in the diagnosis. Even an acute levodopa challenge has low sensitivity and specificity and is associated with significant adverse effects. A clinically based diagnosis by experienced neurologists can have a positive predictive value of 98.6% (when compared with neuro-pathological findings at autopsy). This review of six studies calculated the likelihood ratios of presenting signs and symptoms in predicting PD. Symptoms of tremor, rigidity, bradykinesia, micrographia, shuffling gait and difficulty with 'turning the bed', opening jars and rising from a chair are moderately helpful, as are the glabella tap and heel-to-toe tests.
Comment: Early clinical diagnosis of PD is difficult in general practice. This study quantifies the usefulness of different signs and symptoms.

Nutrition

23-123 Stage-matched nutrition guidance for patients at elevated risk for cardiovascular disease: A randomized intervention study in family practice.

Van Der Veen J, Bakx C, Van Den Hoogen H, et al. J Fam Pract. September 2002. Vol.51. No.9. p.751-8.
Reviewed by Dr Bruce Adlam

Review: Family physicians can select patients for nutrition counselling by using a simple questionnaire based on Stages of Change Model. Dietary interventions result in a decline in fat intake and weight loss (short-term) one year later, unfortunately no

changes in serum lipids were found after one year of intervention. (See also 23-124)
Comment: I only mention this study because it is the first RCT in family practice based on the stages of change model (i.e. pre-contemplative, contemplative, preparation, action, maintenance). In the absence of long-term effects on cholesterol, the emphasis remains of treating elevated lipids with drugs, other benefits of weight reduction not withstanding.

23-124 The challenge of helping patients change.
Vinson DC. J Fam Pract. September 2002. Vol.51. No.9. p.759-60.
Reviewed by Dr Bruce Adlam
Review: See 23-123.

Obstetrics

23-125 Epidurals do not increase the incidence of cesarean delivery.
Harris-Haywood S, Newton WP. J Fam Pract. September 2002. Vol.51. No.9. p.786.
Reviewed by Dr Bruce Adlam
Review: Epidural analgesia provides better control than parenteral opioids without increasing caesarean section rates. There was no comparison with interventions such as social support, which is known to have potent influence on labour course, or the impact of analgesia choice on breast feeding and maternal incontinence. (Original article reviewed: Am J Ostet Gynecol 2002; 186 (suppl): S69-77)

Oncology

23-126 Chemoprevention of breast cancer: recommendations and rationale.
U.S. Preventive Services Task Force. Ann Intern Med. 2 July 2002. Vol.137. No.1. p.56-8.
Reviewed by Dr Mike Slatter
Review: This statement summarises the current recommendations for chemoprevention of breast cancer with Tamoxifen or Raloxifene. The USPSTF recommends that clinicians discuss chemoprevention with women at high risk of breast cancer and at low risk for adverse effects of chemoprevention (stroke, DVT, pulmonary embolus, endometrial cancer). The balance of benefits and harm may be favourable for some women at high risk of breast cancer. The USPSTF recommends against the use of chemoprevention in women at low or average risk for breast cancer.
Comment: This Clinical guideline statement and accompanying editorial (see 23-127) are a good resource for counselling women who are concerned/worried about breast cancer risk. Risk estimation (of both breast cancer and cardiovascular risk) and communication are at the centre of discussion regarding chemoprophylaxis. Those most suitable for chemoprophylaxis would be women in their 40s at high risk of breast cancer with no predisposition to thromboembolic events.

23-127 Making good decisions about breast cancer chemoprevention.
Mulley AG Jr, Sepucha K. Ann Intern Med. 2 July 2002. Vol.137. No.1. p.52-4.
Reviewed by Dr Mike Slatter
Review: See 23-126.

23-128 Screening for colorectal cancer: recommendation and rationale.
U.S. Preventive Services Task Force. Ann Intern Med. 16 July 2002. Vol.137. No.2. p.129-31.
Reviewed by Dr Mike Slatter
Review: This statement summarises the current USPSTF recommendations on screening for colorectal cancer. There is a strong recommendation that clinicians screen all men and women 50 yrs of age or older. The USPSTF found fair to good evidence that periodic faecal occult blood testing (FOBT), annually or bienially, reduces mortality from colorectal cancer. They found fair evidence that sigmoidoscopy, every five years, alone or in combination with FOBT reduces mortality.
Comment: Given that bowel cancer is the second most common cause of cancer in New Zealand (1 000 deaths annually), we need to take notice of these recommendations. The Cancer Society of NZ does not recommend screening for bowel cancer mainly on grounds of cost and a fear that the public health system could not cope with the increased demand for colonoscopy. Certainly if we are serious about preventive medicine this is an area where money would be well spent. See also 23-129 and 23-130.

23-129 Screening for colorectal cancer in adults at average risk: A summary of the evidence for the U.S. Preventive Services Task Force.
Pignone M, Rich M, Teutsch SM, et al. Ann Intern Med. 16 July 2002. Vol.137. No.2. p.E-132 - 41.
Reviewed by Dr Mike Slatter
Review: See 23-128.

23-130 Cost-effectiveness analyses of colorectal cancer screening: A systematic review for the U.S. Preventive Services Task Force.
Pignone M, Saha S, Hoerger T, et al. Ann Intern Med. 16 July 2002. Vol.137. No.2. p.E-96-106.
Reviewed by Dr Mike Slatter
Review: See 23-128.

23-131 Are we doing enough to screen for colorectal cancer? Findings from the 1999 behavioral risk factor surveillance system.
Seeff LC, Shapiro JA, Nadel MR. J Fam Pract. September 2002. Vol.51. No.9. p.761-6.
Reviewed by Dr Bruce Adlam
Review: This was a large survey of 63 000 people aged over 50. Key points include: Strong evidence shows regular colorectal screening reduces colorectal cancer incidence and mortality. Despite this evidence screening rates remain low. Screen-

ing is defined as FOBT annually, sigmoidoscopy five yearly, colonoscopy 10 yearly or double contrast Ba enema five to 10 yearly.
Comment: Physician factors including lack of physician knowledge of the effectiveness of screening was also a key concern.

Paediatrics

23-132 Mortality, severe morbidity, and injury in children living with single parents in Sweden: a population-based study.

Weitoft GR, Hjern A, Haglund B, et al. Lancet. 25 January 2003. Vol.361. No.9354. p.289-95.
Reviewed by Dr Tony Hanne
Review: In this Swedish study nearly one million children were followed over eight years to assess the relative health risk of living with a solo parent as measured by mortality or hospital admission. The children in solo parent families were at two to four times greater risk of psychiatric illness, suicide, injury, and drug and alcohol related events. The risks were generally higher in boys but unrelated to the gender of the parent. Serious attempts were made to allow for confounding factors particularly surrounding poverty. This could account for only a small part of the increased risk. Generous social welfare benefits in Sweden mean that even solo parents on benefits are rarely poor by even OECD standards. (See also 23-133)
Comment: Many previous studies have suggested that divorce was a relatively short-lived crisis in a child's life but these have usually involved small numbers and subjective reporting. There is a strong lobby which will attempt to explain these findings away and to deny the obvious, that lacking one parent causes long-term damage to children. Swedish levels of welfare show that money will not fix this problem.

23-133 What puts children of lone parents at a health disadvantage?

Whitehead M, Holland P. Lancet. 25 January 2003. Vol.361. No.9354. p.271.
Reviewed by Dr Tony Hanne
Review: See 23-132.

Pharmacology

23-134 Oral anticoagulation and risk of death: a medical record linkage study.

Oden A, Fahlen M. BMJ. 9 November 2002. Vol.325. No.7372. p.1073-5.
Reviewed by Dr Len Brake
Review: The increased use of anticoagulation in the past 20 years makes this a timely study. Records for 42 451 patients, 3 533 deaths, and 1.25 million INR measurements have been assessed. The optimal INR for different indications is still unclear.
Comment: This large study confirmed substantial excess mortality at high INR values and suggests optimum INR is 2.2–2.3 irrespective of the indication for anticoagulant treatment.

Practice Management

23-135 Doing away with paper: Part 1. Advice for setting up fully computerised medical records.

Silver D. Aust Fam Physician. June 2002. Vol.31. No.6. p.521-6.
Reviewed by Dr Barry Suckling
Review: Most GPs use computers for simple tasks such as prescribing. This article examines the issues preventing doctors from taking the 'next step', and provides advice on how to prepare for and implement the change to fully computerised records. (See also 23-136).

23-136 Doing away with paper: Part 2. Starting up your new system.

Silver D. Aust Fam Physician. June 2002. Vol.31. No.6. p.527-31.
Reviewed by Dr Barry Suckling
Review: Practice staff and the GP may lack confidence. It is vital to involve all practice staff in the decision making process, as early on as possible to maximise the chance of success. (See also 23-135).
Comment: This paper describes ways to make the changeover in a gentle and easy way.

23-137 Nurse telephone triage for same day appointments in general practice: multiple interrupted time series trial of effect on workload and costs.

Richards DA, Meakins J, Tawfik J, et al. BMJ. 23 November 2002. Vol.325. No.7374. p.1214-9.
Reviewed by Dr Len Brake
Review: The PHO steamroller appears to be gaining momentum. Attempts to lower the cost and number of consultations will do likewise. Same day appointments are a costly burden under the PHO system and attempts to reduce the number of these using nurse phone triage are analysed in this paper.
Comment: Patients were twice as likely to receive telephone advice only and four times as likely to be managed by a nurse. But overall, triage was not less costly than standard management. More patients returned to the surgery within a month, and accident and emergency care costs were up.

Preventive Medicine and Screening

23-138 Evaluation of health-care worker vaccination in a tertiary Australian hospital.

Stewart S, Murray SB, Skull SA. Intern Med J. December 2002. Vol.32. No.12. p.585-92.
Reviewed by Dr Helen Moriarty
Review: A thought provoking article – hospital workers were surveyed by phone. Only 19% had complete vaccination coverage – yet they were working in a tertiary level hospital setting. Some barriers were discussed.
Comment: Is your vaccination up to date? Do you take the lead as an

employer to ensure your staff are correctly covered?

Psychiatry and Psychology

23–139 Atypical antipsychotics for acute agitation: new intramuscular options offer advantages.

Citrome L. Postgrad Med. December 2002. Vol.112. No.6. p.85-96.
Reviewed by Dr Chris Milne

Review: Newer antipsychotics are largely replacing traditional phenothiazines and haloperidol in routine practice for long-term control of psychotic symptoms. The newer agents have a lower incidence of extrapyramidal side effects, and perhaps a specific anti-aggressive effect over time. Depot preparations of these newer agents are being developed.
Comment: This article could well be subtitled – what to do until the CAT team arrives (which may be several hours). Useful resource for a challenging clinical problem.

23–140 Neuroanatomical abnormalities before and after onset of psychosis: a cross-sectional and longitudinal MRI comparison.

Pantelis C, Velakoulis D, McGorry PD, et al. Lancet. 25 January 2003. Vol.361. No.9354. p.281-8.
Reviewed by Dr Tony Hanne

Review: Seventy-five patients at high risk of schizophrenia had MRI scans at baseline and after one year. Significant reduction of grey matter in specific areas was present initially but had increased in frequency and severity particularly in those who developed psychotic illness.
Comment: This confirms previous research which shows neuroanatomical changes in schizophrenia and bipolar disorder and strengthens the case that these changes are related to the disease either as cause or effect. The authors make a good argument, based on these findings for early treatment of prodromal symptoms.

23–141 What are effective treatments for panic disorder?

Sturpe DA, Weissman AM. J Fam Pract. September 2002. Vol.51. No.9. p.743.
Reviewed by Dr Bruce Adlam

Review: Evidence-based answer. CBT and pharmacotherapy (SSRIs , TCAs, BDZ and MAOI) are equally effective. Some patients using SSRIs may respond to lower dosages and it is reasonable to start at half the normal dose. When using TCAs even very low dosages can be sufficient. TCAs take longer to titrate and clomipramine is more effective. Benzodiazepines have a faster onset of action (one week versus four to eight weeks) but do not treat comorbid depression, and are more difficult to discontinue. Adding a BDZ to SSRI for the first three weeks can rapidly stabilise symptoms.

23–142 The active management of depression.

Culpepper L. J Fam Pract. September 2002. Vol.51. No.9. p.769-76.
Reviewed by Dr Bruce Adlam

Review: Fairly useful update for primary care physicians. I would probably wait for the NZ Depression guideline update but, if you can't wait, then this is brief, to the point and includes a good summary of practice strategies to improve care.

23–143 Deliberate self harm in adolescents: self report survey in schools in England.

Hawton K, Rodham K, Evans E, et al. BMJ. 23 November 2002. Vol.325. No.7374. p.1207-11.
Reviewed by Dr Len Brake

Review: A survey using an anonymous self-report questionnaire of 6 020 school pupils aged 15–16 years in England. 6.9% reported an act of self harm and just 12% of those had presented at hospital. Associated factors included recent awareness of self harm in peers, self harm by family members, drug misuse, depression, anxiety, impulsivity and low self esteem.

Respiratory System

23–144 Azithromycin no more effective than vitamin C for acute bronchitis.

Tribastone AD. J Fam Pract. September 2002. Vol.51. No.9. p.783.
Reviewed by Dr Bruce Adlam

Review: Azithromycin is no more effective than Vitamin C in healthy adults. Both are equally effective. (Original article reviewed: Lancet 2002; 359: 1648-54)
Comment: Given the evidence that Vitamin C is not effective in respiratory illness, azithromycin appears equally ineffective. This probably applies to other antibiotics as well.

Rheumatic Diseases

23–145 Glucosamine: A nutraceutical in osteoarthritis.

Phoon S, Manolios N. Aust Fam Physician. June 2002. Vol.31. No.6. p.539-41.
Reviewed by Dr Barry Suckling

Review: Reviews the literature on the effectiveness and safety of glucosamine in osteoarthritis.
Comment: Recent research suggests that it may not only provide symptomatic pain relief but may have a role in chondroprotection.

23–146 Celecoxib versus diclofenac and omeprozole in reducing the risk of recurrent ulcer bleeding in patients with arthritis.

Chan FK, Hung LC, Suen BY, et al. N Engl J Med. 26 December 2002. Vol.347. No.26. p.2104-110.
Reviewed by Dr Raina Elley

Review: This double-blind randomised controlled trial found that, amongst 287 patients with a recent history of ulcer bleeding, celecoxib (200mg bd) was as effective as diclofenac (75mg bd) plus omeprazole (20mg/d) in preventing re-bleeding in the following six months. Re-bleeding at six months with non-selective NSAIDs was 19% from previous studies. This study found re-bleeding rates of 4.9% in the celecoxib group and 6.4% in the diclofenac-omeprazole group (NS). However, renal adverse events were high in both groups (24.3% and 30.8%, respectively), although this was an older high-risk population (mean age 66.5 and 68.8, respectively).

Comment: Renal adverse events were high for both drug regimes.

Sexually Transmitted Diseases

23-147 Screening for sexually transmissible infections in primary health care.

Fairley CK, Bowden FJ. Venereology. September 2002. Vol.14. No.Suppl. p.S3-7.
Reviewed by Dr Helen Moriarty
Review: The authors did a Medline search on 'mass screening'. They used the articles to reference a review on screening. The article promotes the concept of STD screening in populations, and explains the public health aspects – frequency, access, targeting, symptomatic screening, etc.
Comment: The article does not specifically address primary health care as we know it in NZ. The references do not include recent NZ articles on screening. A general overview of the principles of screening.

Sports and Sports Medicine

23-148 Safety measures in amateur boxing.

Jako P. Br J Sports Med. 1 December 2002. Vol.36. No.6. p.394-5.
Reviewed by Dr Chris Milne
Review: Although the outsider's view is that all boxing is much the same, there are several significant differences between amateur and professional boxing that serve to make amateur boxing much safer. In amateur boxing, the wearing of a headguard is mandatory, whereas in pro boxing it is prohibited. In amateur boxing, the ringside doctor has the authority to make a binding decision to suspend the bout at any time. Perhaps most importantly, in amateur boxing the objective is to score points, whereas in pro boxing, the emphasis is on going for the knockout.
Comment: Good summation of a controversial area. Having witnessed numerous amateur boxing bouts up to Olympic level, I would contend that the sport is as safe as it can be made. However, it is still not as safe as tiddlywinks!

23-149 Injuries in professional horse racing in Great Britain and the Republic of Ireland during 1992-2000.

Turner M, McCrory P, Halley W. Br J Sports Med. 1 December 2002. Vol.36. No.6. p.403-9.
Reviewed by Dr Chris Milne
Review: Horse racing is a lot more dangerous than most sports. Professional jockeys have a high level of skill, but are at significant risk given the number of hours each week they spend riding in training and competition. From 1975–2000 there were nine fatalities relating to professional horse racing in Great Britain. Four of these were in flat racing and five were in jump racing events. The most common injuries in this series from 1992 to 2000 were soft tissue type, and these numbered 2 433. There were 419 concussions.
Comment: The results are probably able to be extrapolated to the New Zealand scene, although absolute numbers would be lower. It gives us an abiding respect for those little athletes who guide our horses around the tracks.

23-150 Acute ankle sprains: Keys to diagnosis and return to play.

Anderson SJ. Physician and Sportsmedicine. December 2002. Vol.30. No.12. p.29-35.
Reviewed by Dr Rob Campbell
Review: A general review of the approach to diagnosis and return to play for the athlete with a mild to moderate ankle sprain.
Comment: A reasonable review with a patient hand-out. Does not cover the severe ankle injuries well.

23-151 Shoulder dislocation in young athletes: Current concepts in management.

Park MC, Blaine TA, Levine WN. Physician and Sportsmedicine. December 2002. Vol.30. No.12. p.41-8.
Reviewed by Dr Rob Campbell
Review: A full review of the causes, diagnoses and management of the young athlete who has dislocated his/her shoulder. Recurrence rate is extremely high and in most cases a surgical approach is required.
Comment: The main issue is whether an open or arthroscopic technique is required. In major contact sports the open technique is preferable. A very good review.

Surgery

23-152 Live donor renal transplantation: extending the boundaries.

Gock H, Murphy BF. Intern Med J. December 2002. Vol.32. No.12. p.567-8.
Reviewed by Dr Helen Moriarty
Review: A short and pithy article about use of live donors. Discusses risks and benefits. Mentions the 'marginal' live donor – those who may not be completely ideal donors. Discusses the ethics of altruism in live donors.
Comment: A good need-to-know summary. A more detailed article on audit of Australian practice from 1964–1999 follows on pages 569–74, for the very keen followers on this topic (see 23-153).

23-153 Live donor renal transplantation in Australia 1964-1999: an evolving practice.

Prasad S, Russ G, Faull R. Intern Med J. December 2002. Vol.32. No.12. p.569-74.
Reviewed by Dr Helen Moriarty
Review: See 23-152.

Travel Medicine

23-154 Inhaled salmeterol prevents high-altitude pulmonary edema.

DeBisschop ME. J Fam Pract. September 2002. Vol.51. No.9. p.790.
Reviewed by Dr Bruce Adlam
Review: Salmeterol in this small study in climbers with previous episodes of HAPE is equally effective as Nifedipine, the only other drug specifically shown to prevent HAPE. Unclear whether salmeterol would be effective for the more common less severe stages of high altitude illness. Acetazolamide and

dexamathasone remain the first line treatments for high altitude illness in most climbers, with nifedipine or salmeterol for those individuals at risk of HAPE. (Original article reviewed: N Engl J Med 2002; 346: 1631-6)

Urology

23-155 Managing acute renal colic across the primary-secondary care interface: a pathway of care based on evidence and consensus.

Wright PJ, English PJ, Hungin AP, et al.
BMJ. 14 December 2002. Vol.325. No.7377. p.1408-12.
Reviewed by Dr Len Brake

Review: It is a relief to find that clinical areas that are confused and unclear to you are likewise to others. It is not your brain so much as the situation itself which is difficult. Such is the case in acute renal colic and especially the 'interface' between the GP care (pain relief after diagnosis) and the next step - urological investigation.
Comment: An excellent article covering diagnosis and treatment. Are you a diclofenac person or opiates only? Is urinalysis any help? When to refer. Helpful guidelines.

Virus Diseases

23-156 Infectious mononucleosis in active patients: Definitive answers to common questions.

Auwaerter PG. Physician and Sports-medicine. November 2002. Vol.30. No.11. p.43-50.
Reviewed by Dr Rob Campbell

Review: A full review of infectious mononucleosis. The main issue for athletes is when to return to sport. There is an increased risk of splenic rupture, most of which occur in the first month. Ultrasound is the investigation of choice and return to sport should await the return to normal size spleen (i.e. approx 10cm).
Comment: A useful review.

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