Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Acupunct Med*
Am Fam Physician*
Am J Sports Med*
BMJ*
Br J Dermatol*
Br J Sports Med*
Can Fam Physician Med Fam Can*
Drug Alcohol Rev*
Emerg Med Australas*
Homeopathy*
Int J Obes*
Intern Med J*
J Fam Pract*
JAMA*
Lancet*
N Engl J Med*
Neurology*
Palliative Med*
Pediatrics*
Soc Sci Med*

*Journals indexed in Medline

Acupuncture

27-097 Beyond paradigm: making transcultural connections in a scientific translation of acupuncture

Kim J. Soc Sci Med. June 2006. Vol.62. No.12. p.2960-72.

Reviewed by Dr Alex Chan

Review: This article is a descriptive journey into the historical events leading to, during and after Dr Zang-Hee Cho's investigation into the acupuncture phenomenon using functional magnetic resonance imaging. Dr Cho was the first radiologist who demonstrated activity in the visual cortex of the brain using fMRI when an acupuncture point of the Bladder Meridian on the little toe was stimulated. While this acupuncture point is connected to the eye via the Bladder Meridian according to acupuncture theory, no such connection could be found in conventional western neurophysiology. This created a dilemma over what one should believe. From this, the author pondered on the philosophical concepts of science as a paradigm or as a 'mangle of practice' to explain the scientific translation of acupuncture by Dr Cho.

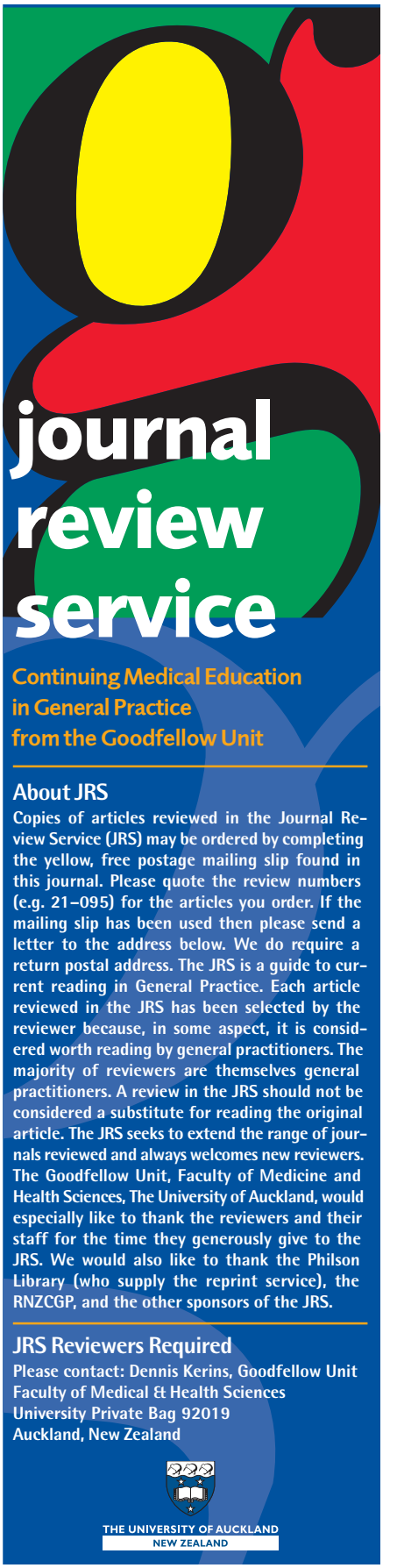
Comment: A very interesting, well researched and philosophical article written by a social scientist on a significant milestone in the history of acupuncture. Well worth reading over the holidays.

27-098 Lack of effect of acupuncture on electromyographic (EMG) activity – a randomised controlled trial in healthy volunteers

Tough L. Acupunct Med. June 2006. Vol.24. No.2. p.55-60.

Reviewed by Dr Alex Chan

Review: Previous studies showed reduced EMG activity in patients with post-stroke spasticity and a strong trend towards reduced activity in patients with tension headache following acupuncture. In this study EMG activity in the wrist extensor muscles was evaluated in 30 healthy volunteers following acupuncture for 20 minutes to LI-4 and LI-10 (which are related to the common wrist extensor muscles); acupuncture for 20 minutes to PC-3 and PC-6 (which are not related to these muscles) and after 20 minutes of resting the forearm on the couch with no intervention. The volunteers underwent all three procedures with the order of the interventions randomised by computer software. No immediate or short-term effect in muscle EMG activity



was found following acupuncture interventions.
Comment: It has always been taught that acupuncture tends to normalise hypo- or hyperfunctioning conditions. Therefore, minimal change in EMG activity, if any, after acupuncture in healthy volunteers would be expected. It is also possible that the negative results could be attributed to the acupuncture stimulation being too short. Maybe increasing the duration to 30 minutes could make a difference?

27-099 Point specificity of acupuncture in the light of recent clinical and imaging studies

Campbell A. Acupunct Med. September 2006. Vol.24. No.3. p.118-22.
Reviewed by Dr Alex Chan
Review: Do different acupuncture points have different specific effects when stimulated? The author reviewed results from four randomised controlled trials from Germany. It was found that while acupuncture was significantly more effective than doing nothing in pain relief, it was not more effective than sham acupuncture. Combining the information obtained from various fMRI and PET scanning which revealed changes in the brain with acupuncture, hypnosis and placebo cream, the author suggested that acupuncture effects in the central nervous system was not unique and could be placebo effects via the limbic system. Thus, location and method of needle insertion may not be as important as taught traditionally.
Comment: A good article for general discussion. There are two issues which have not been considered. Firstly, only acupuncture analgesic effects were considered. There are other acupuncture effects such as those on the autonomic nervous system, the neuro-endocrine system, and the immune system, etc. Secondly, the assumption that sham acupuncture is generally inert may not be valid even though the points used are away from the meridians and known acupuncture points. It has been described in Traditional Chinese Medicine texts for over two thousand years that the whole body surface is covered by the meridians and its branches like a dense network. The skin surface of the body has also been divided into 12 regions, each connected to the related meridians. Acupuncture related techniques such as tuina, moving vacuum cups, quasha, plum-blossom needling, etc., have been developed for stimulating the 12 skin regions to achieve desired clinical effects.

27-100 Relief of low back pain immediately after acupuncture treatment – a randomised, placebo controlled trial

Inoue M, Kitakoji H, Ishizaki N, et al. Acupunct Med. September 2006. Vol.24. No.3. p.103-8.
Reviewed by Dr Alex Chan
Review: This study examined the immediate effect of needling the most painful point for 20 seconds in patients with low back pain, which was localised in a limited area and exacerbated in particular postures. The measurements used are VAS and Schober test scores pre- and immediately post-intervention by blinded evaluators. Patients were randomised to acupuncture and sham acupuncture groups. In the sham group, the acupuncturists tapped the guide tube on the most painful point without a needle and continued to act as if they were inserting a needle. Both groups showed a significant improvement in VAS scores ($P<0.001$ for acupuncture group, $P=0.033$ for the sham acupuncture group), but the reduction was larger in the acupuncture group than the sham group ($P=0.007$). The difference between the acupuncture and sham groups was also significant ($p=0.02$). Improvement in Schober test was only present in the acupuncture group. The between group change also showed a significant difference between the two groups ($P<0.001$).
Comment: The sham group is not 'sham' because a signal was also applied to the most painful point on the body in the form of a tap. The study really only measured the effects of two different forms of stimulation to the body. An easy to read and interesting article.

Alcohol and Substance Abuse

27-101 Global use of alcohol, drugs and tobacco

Anderson, P. Drug Alcohol Rev. November 2006. Vol.25. No.6. p.489-502.
Reviewed by Dr Helen Moriarty
Review: A paper which uses WHO data on the Global Burden of Disease to describe drug, alcohol and tobacco patterns of use across the world. A telling graph of alcohol consumption in Denmark shows how imposition of taxes in the early 1900s dramatically reduced mortality and morbidity directly attributable to alcohol. Reduced heroin importation from Myanmar in the early 2000s cut fatal and non-fatal heroin overdoses in the countries supplied (Canada and Australia), as well as reducing injecting drug use. When GATT agreements opened trade to Asia, tobacco use went up. New Zealand figures are included with those of Australia, Japan, Singapore and Brunei as a wider Western Pacific Region.

27-102 A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs

Ritter A, Cameron J. Drug Alcohol Rev. November 2006. Vol.25. No.6. p.611-24.
Reviewed by Dr Helen Moriarty
Review: Confused about harm reduction concepts? This paper makes it easier. It summarises a literature review on the topic. Harm reduction is well used in the illicit drug therapeutic sense, but not well researched for alcohol or tobacco. Smoking cessation is still preferred over harm reduction, although there are promising developments for harm reduction from smoking: non-smoked nicotine products, reduced exposure products and protection from environmental smoke exposure.

27–103 Mental health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs

Jane-Llopis E, Matytsina I. Drug Alcohol Rev. November 2006. Vol.25. No.6. p.515-36.

Reviewed by Dr Helen Moriarty

Review: Comorbidity of mental health disorders and drug and alcohol use is prevalent in high-income countries where major epidemiological studies have been conducted. It probably exists in all countries – but studies have not been a priority in some regions. Depression and anxiety are the most common known co-morbidities. Cause and effect are difficult to untangle. The paper makes a strong case for early intervention.

Cardiovascular System

27–104 Lifetime cost effectiveness of simvastatin in a range of risk groups and age groups derived from a randomised trial of 20 536 people

Heart Protection Study Collaborative. BMJ. 2 December 2006. Vol.333. No.7579. p.1145-9.

Reviewed by Dr Len Brake

Review: As the gush of blood was staunched during my latest coronary angiogram, the cardiologist remarked that a statin should be put in the water supply. At the time I thought he was joking in an attempt to lighten the mood during his arterial intervention. **Comment:** This massive trial concludes that treatment with statins is cost-effective in a wider population than is routinely treated at present, the details include the actual cost savings, especially when cheaper generic versions are used. So, maybe the idea of mass medication is not such a joke.

27–105 Excessive lowering of blood pressure may cause harm

Shaughnessy AF. Am Fam Physician. 15 October 2006. Vol.74. No.8. p.1407-8.

Reviewed by Dr Andrea Steinberg

Review: *Clinical Question:* Can aggressive lowering of blood pressure in patients with coronary artery disease be dangerous? Research has hinted at a J-curve response to lowering blood pressure: As blood pressure is lowered, mortality and morbidity decrease to a point after which further lowering is associated with higher mortality and morbidity. Common guidelines and conventional wisdom do not take this risk into account, advocating various degrees of aggressive blood pressure control on the basis of other risk factors. *Study Design:* Cohort (prospective) – 22 576 patients were evaluated in an outpatient setting for the relationship between average diastolic blood pressure and the primary outcome of all-cause death, nonfatal stroke, and nonfatal myocardial infarction, over a median of 2.7 years. *Synopsis:* The best results were a diastolic blood pressure between 80 and 90 mm Hg. A diastolic blood pressure between 70 and 80 mm Hg was associated with slightly, but not significantly, increased poor outcomes, although patients with blood pressures of less than 70 mm Hg experienced poor outcomes at the same rate as those with readings higher than 100 mm Hg. *Bottom Line:* Lower is not always better. Despite a push toward lower blood pressure in many populations, poor outcomes (i.e. mortality, myocardial infarction, and stroke) are increased in patients with coronary artery disease if their diastolic blood pressure consistently remains lower than 70 mm Hg. (Level of evidence: 1b) (Original article reviewed: Ann Intern Med June 20, 2006;144:884-93.)

27–106 Coffee does not increase risk of developing heart disease

Ebell M. Am Fam Physician. 15 October 2006. Vol.74. No.8. p.1408, 1410.

Reviewed by Dr Andrea Steinberg

Review: *Clinical Question:* Does coffee consumption increase the risk of heart disease? *Setting:* Population-based. *Study Design:* Cohort (prospective). *Synopsis:* Many patients avoid coffee, often on the advice of their physicians, because of concerns that it may increase the risk of heart disease. The largest and longest study to date on the subject combines data from the Health Professionals Follow-up Study (n=44 005) and the Nurses' Health Study (n=84 488). These studies began in 1986 and 1976, respectively, and provide 14 and 20 years of follow-up. None of the participants had coronary artery disease (CAD) at the beginning of the study. Participants reported their typical daily caffeine consumption via surveys every four years. The primary outcome was nonfatal myocardial infarction or fatal CAD before June 1, 2000. After adjusting for age, smoking, and other risk factors, no association was found for total caffeine

intake, decaffeinated coffee, or tea. *Bottom Line:* There is no evidence that coffee consumption increases the likelihood of developing heart disease. (Original article reviewed: Circulation May 2, 2006;113:2045-53.)

27–107 Homocysteine-lowering treatments for CVD?

Carter C. Am Fam Physician. 1 November 2006. Vol.74. No.9. p.1606.

Reviewed by Dr Andrea Steinberg

Review: *Question:* Observational studies indicate a positive association between high homocysteine levels and risk of cardiovascular disease (CVD). Folic acid and vitamins B6 and B12 are known to lower homocysteine levels. Will such supplementation decrease adverse cardiovascular outcomes in high risk groups? Two trials recently studied the effectiveness of these treatments for improving cardiovascular outcomes in high-risk patients. (5 522 patients with known vascular disease or diabetes followed for five years; and 3 749 patients post MI followed for three years.) *Bottom line:* Despite decrease in plasma homocysteine levels, there was no difference in the outcomes of cardiac death, myocardial infarction, and stroke between the two groups. The findings of both studies do not support supplementation with folic acid and B vitamins for preventing cardiovascular events in high-risk patients. (Original articles reviewed: N Engl J Med April 13, 2006;354:1567-77; N Engl J Med April 13, 2006;354:1578-88.)

27–108 The role of BNP testing in heart failure

Doust J, Lehman R, Glasziou P. Am Fam Physician. 1 December 2006. Vol.74. No.11. p.1893-8.

Reviewed by Dr Andrea Steinberg

Review: Natriuretic peptides have several actions: (1) down-regulating the sympathetic nervous system and the renin-angiotensin-aldosterone system, (2) facilitating natriuresis and diuresis through the afferent and efferent haemodynamic mechanisms of the kidney and distal tubules, (3) decreasing peripheral vascular resistance, and (4) increasing smooth muscle relaxation. The ventricles in the heart primarily secrete the hormone BNP (brain natriuretic peptide) as a response to left ventricular stretching or wall tension, perhaps only after a prolonged period of volume overload. Increases in BNP levels may be caused by intrinsic cardiac dysfunction or may be secondary to other causes such as pulmonary or renal diseases (e.g. chronic hypoxia). The high negative predictive value of BNP tests is particularly helpful for ruling out heart failure. Treatment with angiotensin-converting enzyme inhibitors, angiotensin-II receptor blockers, spironolactone, and diuretics reduces BNP levels, suggesting that BNP testing may have a role in monitoring patients with heart failure. However, patients with treated chronic stable heart failure may have levels in the normal range. BNP levels correlate well with other measures of cardiac status (e.g. NYHA) and appear to be a strong predictor of risk of death and cardiovascular events in patients previously diagnosed with heart failure or cardiac dysfunction.

Comment: In the future, BNP testing may have an increasing role in detecting, monitoring, and perhaps preventing chronic heart failure.

27–109 Sudden cardiac death in the young: a clinical genetic approach

Ingles J, Semsarian C. Intern Med J. January 2007. Vol.37. No.1. p.32-7.

Reviewed by Dr Helen Moriarty

Review: A discussion paper which outlines the impact and causes of sudden cardiac death of young persons. This article comes from the Genetic Heart Disease Clinic in New South Wales, but is not an overt advertisement for their services. A list of known genetic causes of sudden cardiac death is surprisingly long. It includes eight types of long QT syndrome, most due to variants of potassium channel subunits. Most of such conditions are autosomal dominant. The importance of a thorough history is explained, and this is a job the GP can do well.

27–110 Lowering homocysteine does not reduce CVD

J Fam Pract. July 2006. Vol.55. No.7. p.570.

Reviewed by Dr Bruce Adlam

Review: Supplementation with folic acid and B vitamins is ineffective for adults aged 55 years and older with known cardiovascular disease (CVD) or diabetes. A second report in the same issue (N Engl J Med 2006; 354: 1578- 88) found that similar supplementation in patients with a recent acute myocardial infarction was not helpful and may actually increase the risk of a bad cardiovascular outcome (LOE: 1b). (Original article reviewed: N Engl J Med 2006; 354: 1567-77).

27–111 Excluding deep vein thrombosis safely in primary care

Toll DB, Oudega R, Bulten RJ, et al. J Fam Pract. July 2006. Vol.55. No.7. p.613-8.

Reviewed by Dr Bruce Adlam

Review: Most primary care patients with suspected deep vein thrombosis (DVT) – even if suspicion is low – are referred for burdensome and costly tests such as ultrasonography of the legs or venography. About 25% of these patients end up having DVT. This clinical tool claims to safely exclude the presence of DVT in about one quarter of patients, minimising the number of unnecessary patient referrals. The formula of the diagnostic rule is: (1×male gender)+(1×oral contraceptive use)+(1×presence of malignancy)+(1×recent surgery)+(1×absence of trauma)+(1×vein distension)+(2×calf difference = 3 cm)+(6×abnormal D-dimer test result). Each indicator is assigned the value 1 if present, and 0 if absent. For a score of 0–3, DVT prevalence is 0.7%, low risk, score 4–6, DVT prevalence is 4.5%, moderate risk score 7–9, DVT prevalence is 21.7%, and high risk, score 10–13, DVT prevalence is 54.3%. Using a score threshold =3 (very low risk) and retaining these patients in primary care would result in a 23% reduction in referrals.

Comment: Note this is a Netherlands based study and results may not be generalisable to the NZ population.

27–112 Multiple biomarkers for the prediction of first major cardiovascular events and death

Wang, TJ, Gona P, Larson MG, et al. N Engl J Med. 21 December 2006. Vol.355. No.25. p.2631-9.

Reviewed by Dr Raina Elley

Review: Serum levels of B-type natriuretic peptide (BNP) and the urine albumin-creatinine ratio are predictive of first major CVD event (respective hazard ratios: 1.25 and 1.20 per 1 SD increment in the log values), over and above traditional risk factors (age, gender, smoking, BP, lipids, diabetic status, etc). These biomarkers and C-reactive protein, renin and homocysteine are also predictive of death from any cause. This study used the Framingham Heart Study cohort of 3209 patients followed over a median of 7.4 years.

Comment: Despite the biomarkers significant predictors of CVD event and death, they add only a small amount of information to traditional CVD risk factors. Therefore, they are unlikely to become routine markers of risk, except in certain subpopulations (e.g. urine albumin creatinine ratio in people with diabetes and BNP in CHF, as they also indicate other pathology, including renal impairment and worsening CHF, respectively).

Cerebrovascular System

27–113 What is the best management for patients who have a TIA while on aspirin therapy?

Ahmed N, Coffey JB. J Fam Pract. July 2006. Vol.55. No.7. p.627-8.

Reviewed by Dr Bruce Adlam

Review: *Evidence-based answer:* Alternative antiplatelet therapy for stroke prevention is indicated for patients who experience transient ischaemic attacks (TIAs) while on aspirin therapy (strength of recommendation: A). The combination of aspirin and extended-release dipyridamole reduces the risk of stroke following a TIA (SOR: A). Thienopyridines (e.g. clopidogrel) are an alternative for patients at high risk for a cardioembolic event but clopidogrel has not shown significant reduction in reoccurrence of stroke and has not been studied for patients with a previous TIA.

Comment: While the combination of aspirin and clopidogrel has shown benefit in acute coronary syndromes, what's good for the heart may not necessarily be good for the brain. The MATCH study showed potential increases in bleeding from combination therapy and there is good evidence that aspirin and a thienopyridine do not provide significant additional reduction in secondary strokes (SOR: A).

27–114 High-dose atorvastatin after stroke or transient ischmic attack

The Stroke Prevention by Aggressive Reduction in Cholesterol Levels 6 (SPARCL) Investigators. N Engl J Med. 10 August 2006. Vol.355. No.6. p.549-59.

Reviewed by Dr Raina Elley

Review: This RCT of over 4000 patients found that Atorvastatin (80mg/day) post stroke or TIA reduces the five-year absolute risk of subsequent stroke by 2.2% (NNT over five years was 46). Absolute risk reduction in any cardiovascular event was 3.5% (These patients had no known previous CHD). The death rate was similar in the intervention and control groups and there were more haemorrhagic strokes and elevated LFTS in the Atorvastatin group.

Comment: There is a known association between lowering LDL and reduced stroke risk. However, the benefits of a statin are still small for prevention of stroke and substantially smaller than the benefit in protecting against coronary heart disease, especially in secondary prevention (4S study). The likely benefits to patients who are post CVA/TIA but with no CHD should be weighed against the possible harm.

Communicable Diseases, Infections and Parasites

27–115 Varicella

Heininger U, Seward JF. Lancet. 14 October 206. Vol.368. No.9544. p.1365-76.

Reviewed by Dr Tony Hanne

Review: What is normally a mild childhood illness can occasionally be a serious and even fatal event particularly in immuno-compromised patients. Herpes zoster is increasing, presumably in part because of an ageing population, and its sequelae can be disabling. Treatment has not really advanced beyond Acyclovir where indicated. The greatest interest therefore is around prevention by immunisation, the use of which has become slowly more widespread over the past 10 years. Acceptance internationally has been increasing in the last two years by combining the varicella vaccine with MMR. Use of the vaccine has reduced morbidity and mortality but it will take time to demonstrate a reduction in herpes zoster.

Comment: This thorough article in the *Lancet* Seminar series reviews the basics of a common disease but at the same time looks into the future. Australia has included varicella in its childhood immunisation schedule. Will New Zealand follow?

Dermatology

27–116 Diagnosis and management of granuloma annulare

Cyr PR. Am Fam Physician. 15 November 2006. Vol.74. No.10. p.1729-34.

Reviewed by Dr Andrea Steinberg

Review: A review of this benign, asymptomatic, self-limiting papular eruption of unknown aetiology, found in patients of all ages, presenting usually as grouped flesh-coloured to erythematous papules in an enlarging annular shape. In more than one half of patients, it resolves spontaneously within two months to two years, but may last as long as 10 years. Differential diagnosis includes: tinea corporis, pityriasis rosea, nummular eczema, psoriasis, or erythema migrans of

Lyme disease in those who have travelled to areas where this is endemic. The lack of any surface changes to the skin (no scale or associated vesicles or pustules) is the key distinguishing feature – the skin surface is smooth. Because localised granuloma annulare is self-limited and asymptomatic, treatment usually is not necessary. Nevertheless, many patients remain troubled by the appearance and persist in seeking treatment. For patients insisting on treatment, options include intralesional corticosteroid injection into the elevated border, topical corticosteroids under occlusion, cryotherapy, and electrodesiccation. All of these treatments may cause scarring and atrophy. Reassurance that the condition will self-resolve may be the best option.

Comment: Yet another mysterious disease that we can diagnose but can't cure!

27–117 Specialist dermatology clinics for organ transplant recipients significantly improve compliance with photoprotection and levels of skin cancer awareness

Ismail F, Mitchell I, Casabonne D, et al. Br J Dermatol. November 2006. Vol.155. No.5. p.916-25.

Reviewed by Dr Shane Reti

Review: This study evaluated whether routine consultation in a specialist dermatology organ transplant recipient clinic improves understanding of skin cancer risk and compliance with photoprotection measures.

Comment: Organ transplant recipients (OTRs) have 100-fold increased risk of developing squamous cell carcinomas. Cumulative exposure to ultraviolet radiation is the main risk factor and there is evidence that lack of dermatological surveillance may be responsible for poor levels of knowledge and photoprotection among OTRs. A reminder to us that OTR are at increased risk and require extra skin surveillance.

27–118 Dermoscopy of facial nonpigmented actinic keratosis

Zalaudek I, Giacomel J, Argenziano G, et al. Br J Dermatol. November 2006. Vol.155. No.5. p.951-6.

Reviewed by Dr Shane Reti

Review: Examination of the dermoscopic features of actinic/solar keratoses (AK). Four essential dermoscopic features were observed in facial AK: (i) erythema, revealing a marked pink-to-red 'pseudonetwork' surrounding the hair follicles (95%); (ii) white-to-yellow surface scale (85%); (iii) fine, linear-wavy vessels surrounding the hair follicles (81%); and (vi) hair follicle openings filled with yellowish keratotic plugs (66%) and/or surrounded by a white halo (100%). These features combined, in 95% of cases, to produce a peculiar 'strawberry' appearance.

Comment: Diagnosis of actinic/solar keratoses is usually a straight forward clinical diagnosis, however, for those experienced with dermatoscopes these features may further improve the diagnosis although studies larger than 41 subjects probably need to verify these findings.

27–119 Striae gravidarum in primiparae

Atwal GS, Manku LK, Griffiths CE, et al. Br J Dermatol. November 2006. Vol.155. No.5. p.965-9.

Reviewed by Dr Shane Reti

Review: This study determined that maternal age, body mass index, weight gain and neonatal birth weight were independently associated with the occurrence of striae. It appears that the group at highest risk of developing severe striae are teenagers.

Comment: Useful to separate out the independently related factors, although not entirely surprising from clinical observations. Having said that, the question remains – so what? Admittedly the study never set out to examine treatment options, and so the question is left open as to suitable management. I find most mothers have and are being advised a mix of topical creams ranging from peanut oil to aloe vera.

27–120 Cutaneous innervation before and after one treatment period of acpuncture

Carlsson CP, Sundler F, Wallengren J. Br J Dermatol. November 2006. Vol.155. No.5. p.970-6.

Reviewed by Dr Shane Reti

Review: Ten subjects assessed for an effect of acupuncture on itch (histamine prick test) showed a statistically significant histological improvement in neuropathic itch but not histamine induced itch.

Comment: I don't see anything in this study that sways me away from standard pruritus management, identifying any causes, empirical trial of antihistamines and topical corticosteroids and emmolients. I guess along with other alternative treatments for itch acupuncture could be considered, but not enough subjects or evidence in this study or to date really.

27–121 Prevalence of vulval lichen planus in a cohort of women with oral lichen planus: an interdisciplinary study

Belfiore P, Di Fede O, Cabibi D, et al. Br J Dermatol. November 2006. Vol.155. No.5. p.94-8.

Reviewed by Dr Shane Reti

Review: This study showed a 57% prevalence of Vulval Lichen Planus in selected patients with Oral Lichen Planus. The high prevalence of VLP of 92% in the women who were free of vulval symptoms confirmed the usefulness of this careful integrated approach.

Comment: Typical oral LP ranges from the reticulate white leukoplakia type eruption to blistering and ulceration. This study reminds us of the high incidence of vulval LP also likely to be present even in asymptomatic subjects. Management might initially range between observation and mod–strong corticosteroids.

27–122 Evaluation of methotrexate and corticosteroids for the treatment of localized scleroderma (morphoea) in children

Weibel L, Sampaio MC, Visentin MT, et al. Br J Dermatol. November 2006. Vol.155. No.5. p.1013-20.

Reviewed by Dr Shane Reti

Review: Thirty-four children with Localised Scleroderma (Morphoa) were given pulsed intravenous methylprednisolone followed by oral prednisolone on a reducing regimen and maintenance treatment with methotrexate. Treatment was effective in halting the disease (92%), however 44% developed relapse, and adverse effects were moderate, but transient.
Comment: Seems like very aggressive therapy to me for what is a mostly self-limiting condition. I would suggest biopsy confirmation followed by a moderate topical corticosteroid might be more conservative.

27–123 Management of onychomycosis and awareness of guidelines among dermatologists

Rajpar SF, Abdullah A. Br J Dermatol. November 2006. Vol.155. No.5. p.1080-2.
Reviewed by Dr Shane Reti
Review: This letter summarises the evidence-based management guidelines on onychomycosis that have recently been published by the British Association of Dermatologists (BAD). The key recommendations are that mycological confirmation of infection should be obtained before commencing treatment, topical treatments are most suitable for superficial white onychomycosis or very early distal and lateral subungual onychomycosis (DLSO), terbinafine is the systemic antifungal agent of choice in adults with dermatophyte onychomycosis, and an alternative drug with or without nail avulsion should be considered for treatment failures.
Comment: A reminder here that as practitioners we must not become as misled as the general public are with direct to consumer advertising suggesting that all discoloured and scaling nails are fungal – the vast majority will be simply dystrophic – nil to do – get over it!

Diabetes

27–124 Epidemic obesity and type 2 diabetes in Asia

Yoon K-H, Lee J-H, Kim J-W, et al. Lancet. 11-17 November 2006. Vol.368. No.9548. p.1681-8.
Reviewed by Dr Tony Hanne
Review: Rapid urbanisation in Asia, particularly in China and India, has been accompanied by a dramatic and continuing rise in type 2 diabetes which threatens to overwhelm their health systems. The main factors are a changing diet and decreased physical activity. The Asian epidemic is expanding at least as fast as in Western countries but there are some striking differences. The average age of onset is lower. Complications come quicker. The disease is associated with a much lower threshold of obesity.
Comment: Because of the rapid growth in Asian immigration to New Zealand we should be alert to the implications of this trend. We have tended to focus on Maori and Pacific patients by screening them earlier and more often than Europeans. This awareness should now extend to Chinese, Indian, Korean and Filipino patients particularly. The trap for us is to fail to recognise that a BMI of 22 can represent obesity in many Asian patients. Waist/hip ratios are more helpful.

27–125 Sustained reduction in the incidence of type 2 diabetes by lifestyle intervention: followup of the Finnish Diabetes Prevention Study

Lindstrom J, Ilanne-Parikka P, Peltonen M, et al. Lancet. 11-17 November 2006. Vol.368. No.9548. p.1673-9.
Reviewed by Dr Tony Hanne
Review: The original trial compared the extent of progression from impaired glucose tolerance to diabetes over a period of four years in those subject to intensive lifestyle intervention by diet and exercise, and a control group who received just normal supervision. The intervention programme aimed to reduce the proportion of the diet which was fat, particularly saturated fat, increase the proportion of fibre, and achieve at least 30 minutes per day of moderate exercise. Intervention dropped the rate of diabetes from 4.3 to 7.6 per 100 person-years. Active intervention ceased but both groups have now been followed for a further three years. The benefit has largely continued with rates after seven years standing at 4.6 and 7.2, still a 36% reduction in relative risk.
Comment: There are two encouraging features of this trial. Firstly the original intervention which was labour intensive for the health team as well as the patients did not have to be continued indefinitely although it would almost certainly be useful to continue to reinforce the original messages. Secondly the intervention programme only achieved an average weight reduction of two kilos while the control group remained unchanged, and yet there was such substantial benefit.

27–126 Effect of ramipril on the incidence of diabetes

The DREAM Trial Investigators. N Engl J Med. 12 October 2006. Vol.355. No.15. p.1551-62.
Reviewed by Dr Raina Elley
Review: ACE inhibitors (e.g. Ramipril) do not reduce the progression from impaired glucose tolerance (IGT) or impaired fasting glucose (IFG) to diabetes (or death) in people without previous CVD. There was some indication of improved response to glucose load and regression to normoglycaemia. This was a double blind RCT of up to 15mg/day of Ramipril compared with placebo over three years.
Comment: This is in contrast to weight-loss, physical activity and metformin, all of which have been shown in previous trials to reduce the progression of IGT/IFG to diabetes over three years. Also, the HOPE study showed that an ACE inhibitor can reduce development of diabetes in people with high CVD risk.

Diagnosis

27–127 Testicular torsion

Ringdahl E, Teague L. Am Fam Physician. 15 November 2006. Vol.74. No.10. p.1739-43.
Reviewed by Dr Andrea Steinberg
Review: Testicular torsion affects one in 4 000 males younger than 25 years and usually occurs in the absence of any precipitating event; only four to eight per cent of cases are a result of trauma. Early diagnosis and definitive management are the keys to avoid testicular loss. An absent ipsilateral cremasteric reflex is the most accurate sign of testicular torsion. Doppler ultrasonography should be done only in equivocal cases in which suspicion for torsion is low. Any patient with a history and physical examination suspicious for torsion should have immediate surgery, preferably within six hours of onset of symptoms. Manual detorsion by external rotation of the testis can be successful, but restoration of blood flow must be confirmed following the manoeuvre. Testicular salvage rate is 90 per cent if detorsion occurred less than six hours from the onset of symptoms; this rate falls to 50 per cent after 12 hours and to less than 10 per cent after 24 hours. The differential diagnosis of the acutely painful scrotum includes testicular torsion, trauma, epididymitis/orchitis, incarcerated hernia, varicocele, idiopathic scrotal oedema, and torsion of the appendix testis. (Patient page attached)
Comment: The most common misdiagnosis is epididymitis. All prepubertal and young adult males with acute scrotal pain should be considered to have testicular torsion until proven otherwise.

27–128 Update on exercise stress testing

Fletcher GF, Mills WC, Taylor WC. Am Fam Physician. 15 November 2006. Vol.74. No.10. p.1749-54.
Reviewed by Dr Andrea Steinberg
Review: The use of the stress ECG in several categories of disease is discussed in this comprehensive review of evaluating patients who have or are at risk of developing cardiovascular disease. The timing of the stress ECG is important in acute coronary syndromes, and depends on risk stratification. Low risk patients may be tested in an emergency care setting before discharge. Exercise stress testing may provide valuable prognostic information in asymptomatic men older than 45 years who have risk factors. Exercise stress testing may also be used to identify patients with abnormal blood pressure responses that may be a precursor of hypertension.
Comment: This evidence based summary of current recommendations for exercise stress testing in ischaemic heart disease and acute coronary syndromes is useful for the GP who wishes to understand more about the timing of such testing.

27–129 MRI not accurate for diagnosis of MS

J Fam Pract. July 2006. Vol.55. No.7. p.575.
Reviewed by Dr Bruce Adlam
Review: This systematic review reveals Magnetic Resonance Imaging (MRI) is not particularly useful in ruling in or ruling out multiple sclerosis (MS). Relying on it will result in over-diagnosis; using it to rule out MS will cause you to miss about half of those eventually clinically diagnosed (LOE: 1a). (Original article reviewed: BMJ 2006; 15: 875-84).

Emergency Medicine

27–130 Guideline 4: Airway: Australian Resuscitation Council Guidelines 2006

Australian Resuscitation Council. Emerg Med Australas. August 2006. Vol.18. No.4. p.325-7.
Reviewed by Dr Jocelyn Tracey
Review: These four guidelines are evidence-based, well written, easy to follow, and have clear diagrams. They follow the international trend to put more importance on chest compressions, with a higher compression to ventilation ratio. See 27-131, 27-132 and 27-133.
Comment: Unfortunately these are not the Australasian guidelines – the NZ Resuscitation Council is about to release the new NZ guidelines.

27–131 Guideline 5: Breathing: Australian Resuscitation Council 2006

Australian Resuscitation Council. Emerg Med Australas. August 2006. Vol.18. No.4. p.328-9.
Reviewed by Dr Jocelyn Tracey
Review: See 27-130, 27-132 and 27-133.

27–132 Guideline 6: Compressions: Australian Resuscitation Council 2006

Australian Resuscitation Council. Emerg Med Australas. August 2006. Vol.18. No.4. p.330-1.
Reviewed by Dr Jocelyn Tracey
Review: See 27-130, 27-131 and 27-133.

27–133 Guideline 7: Cardiopulmonary resuscitation: Australian Resuscitation Council Guideline 2006

Australian Resuscitation Council. Emerg Med Australas. August 2006. Vol.18. No.4. p.332-4.
Reviewed by Dr Jocelyn Tracey
Review: See 27-130, 27-131 and 27-132.

27–134 Guidelines 11.1–11.11: Adult advanced life support: Australian Resuscitation Council Guidelines, 2006

Australian Resuscitation Council. Emerg Med Australas. August 2006. Vol.18. No.4. p.337-56.
Reviewed by Dr Jocelyn Tracey
Review: This is a comprehensive evidence-based guideline covering ACLS protocols, precordial thump, cricoid pressure, defibrilation, medication and equipment.
Comment: Unfortunately these are not the Australasian guidelines – the NZ Resuscitation Council is about to release the new NZ guidelines.

27–135 Guidelines 12.1–12.7: Paediatric advanced life support: Australian Resuscitation Council Guidelines, 2006

Australian Resuscitation Council. Emerg Med Australas. August 2006. Vol.18. No.4. p.357-71.
Reviewed by Dr Jocelyn Tracey

Review: This is a comprehensive evidence-based guideline covering diagnosis, ACLS protocols, medication and arrythmias.
Comment: Unfortunately these are not the Australasian guidelines – the NZ Resuscitation Council is about to release the new NZ guidelines.

Gastroenterology

27–136 Do opiates affect the clinical evaluation of patients with acute abdominal pain?

Ranji SR, Goldman IE, Simel DL, et al. JAMA. 11 October 2006. Vol.296. No.14. p.1764-74.
Reviewed by Dr Len Brake
Review: Yes and no. Opiates can alter the physical examination findings but this does not lead to management errors. In any event a GP often sees the patient prior to any medication effect. (Patient page attached.)
Comment: There is no reason why an examination can be made, the findings recorded and then suitable opiate analgesia administered. That is assuming the referral notes are given credence by the surgical team. Which is another issue altogether.

27–137 Diagnosis of acute abdominal pain in older patients

Lyon C, Clark DC. Am Fam Physician. 1 November 2006. Vol.74. No.9. p.1537-44.
Reviewed by Dr Andrea Steinberg
Review: The presentation of an older patient with abdominal pain may be very different from that seen in a younger patient. Older patients tend to present later in the course of their illness and have more non-specific symptoms. Clinical assessment may be impaired due to absent or low fever/leucocytosis or hypothermic response despite a serious bacterial infection or surgical condition; altered pain perception from chronic pain medications; lower likelihood of localised tenderness despite a focal surgical condition; reduced rebound and guarding from decreased abdominal wall musculature; suppressed tachycardia from medications or intrinsic cardiac disease. Common causes and pitfalls in differential diagnosis in this group of patients are discussed. Extra abdominal causes should always be considered such as UTI, MI, pneumonia, PE, CHF with hepatic congestion.
Comment: Morbidity and mortality amongst this group is high, and the physical examination can be misleadingly benign, even with catastrophic conditions such as abdominal aortic aneurysm rupture and mesenteric ischaemia.

27–138 Chronic constipation: Let symptom type and severity direct treatment

Bleser SD. J Fam Pract. July 2006. Vol.55. No.7. p.587-93.
Reviewed by Dr Bruce Adlam
Review: Practice recommendations from this article include: Increased fibre intake through diet (C) or fibre supplements (B) is an appropriate initial therapy for chronic constipation. Osmotic and stimulant laxatives may be administered to patients who do not respond to more conservative measures if the limitations of these agents are explained (B). Tegaserod, a selective 5-hydroxytryptamine type 4 (5-HT4) receptor partial agonist, is more effective than placebo at relieving symptoms of chronic idiopathic constipation in patients younger than 65 years of age (A). Patients with suspected defecation disorders and those with treatment-refractory symptoms should be referred to a gastroenterologist for further evaluation (C).
Comment: The article includes an interesting table with NNT for the various options. Surprisingly there are no well controlled trials on dietary fibre and no strong evidence of whether laxatives or fibre work better, or whether one laxative class is superior to another.

Geriatrics

27–139 Prospective aetiological study of diaper dermatitis in the elderly

Foureur N, Vanzo B, Meaume S, et al. Br J Dermatol. November 2006. Vol.155. No.5. p.941-6.
Reviewed by Dr Shane Reti
Review: Forty-six consecutive patients presenting with diaper dermatitis (DD) were included in this study. Clinical evaluation, skin swabs for bacterial and mycological cultures, patch testing and skin biopsy were performed at inclusion. This was followed by one month of topical antifungal cream and, if needed, by oral fluconazole for the second month. Causes of DD were established for 38 patients: 24 had candidiasis (63%), six irritant dermatitis (16%), four eczema (11%) and four psoriasis (11%). After two months of treatment, 27 of 37 (73%) patients were cured and five of 37 were improved.
Comment: Note the high incidence of candidiasis and the response to empirical antifungal and the duration of treatment. Probably a reasonable first line empirical response.

Gynaecology

27–140 Menstruation in girls and adolescents: using the menstrual cycle as a vital sign

American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Pediatrics. November 2006. Vol.118. No.5. p.2245-50.
Reviewed by Dr Jocelyn Tracey
Review: A summary of what is normal and what is not normal for adolescent girls' periods.
Comment: A useful reference.

27–141 Diagnosis and management of endometriosis

Mounsey AL, Wilgus A, Slawson DC. Am Fam Physician. 15 August 2006. Vol.74. No.4. p.594-600.
Reviewed by Dr Andrea Steinberg
Review: This is a comprehensive review of this common condition. Laparoscopy is still the preferred method of diagnosis, after thorough clinical review and exclusion of other causes of the pelvic pain. Although there is a wealth of interest in the use of serum markers to diagnose endometriosis, none are accurate

enough to be used in routine clinical practice. CA 125 may be useful as a marker for disease monitoring and treatment follow-up. Medical therapies for patients with endometriosis include the well-established modalities of analgesia (including NSAIDs), oral contraceptive pills, androgenic agents (e.g. danazol), progestogens as well as the newer gonadotropin-releasing hormone analogues (e.g. goserelin), and anti-progestogens (e.g. gestrinone). (Patient page attached).

Comment: The prevalence of endometriosis in the general population is estimated to be 10 per cent. A much higher prevalence of up to 82 per cent occurs in women with pelvic pain, and should always be on the list of differential diagnosis in this group.

27–142 Below the belt: Approach to chronic pelvic pain

Bordman R, Jackson B. Can Fam Physician Med Fam Can. December 2006. Vol.52. p.1556-62.

Reviewed by Dr Mike Lyons

Review: The authors are family doctors in Toronto and Ottawa who have developed a tool kit for GPs and patients to manage benign uterine conditions. The article starts with a case history of a 37-year-old female with lower abdominal pain for three years. It continues to outline all conditions considered in differential diagnosis but highlighting four – endometriosis, adhesions, interstitial cystitis and irritable bowel. Investigations are sensible. Treatments focus on pain, the specific diagnosis and dealing psychologically with the patient's concerns by adopting a multifaceted approach. The case history is concluded at the end of the article.

Comment: May help some of your heartsink thirty-something-year-old female patients.

Homeopathy

27–143 Outcomes from homeopathic prescribing in medical practice: A prospective, research-targeted, pilot study

Mathie RT, Robinson TW. Homeopathy. October 2006. Vol.95. No.4. p.199-205.

Reviewed by Dr Mimi Irwin

Review: This pilot study aimed to review homeopathic practice in the real world. Fourteen homeopathic physicians recorded data in consecutive patients over a six-month period. Data on 2488 appointments was collected. There were a total of 1783 patients seen and their progress after two or more visits was recorded for 961 patients. The data recorded included age and gender of patients, the medical complaint, whether it was chronic or acute, patient assessed outcome on a 7-point Lickert scale and the use of conventional treatment. The homeopathic treatment or no treatment was also recorded. The mean age was 41.5 years and the patients were predominantly female at 71.1%. The patients reported a positive outcome in 75.9% of cases and the highest positive outcomes were for GI and ENT complaints. There were also high levels of satisfaction for the treatment of depression, anxiety and IBS. The success rate in treating CFS/ME was relatively modest.

Comment: This pilot study shows that it can be a relatively simple matter for busy GPs to track the progress of patients seen. This is not a controlled study but the doctors participating found filling in the data sheet not too onerous and helpful in seeing the impact of their care. The positive outcome for the treatment of anxiety, depression and IBS can be used to inform future studies, which could be controlled thus giving an evidence base for the treatment of specific conditions with homeopathy.

Information Systems

27–144 Googling for a diagnosis – use of a Google as a diagnostic aid: Internet based study

Tang H, Ng JH. BMJ. 2 December 2006. Vol.333. No.7579. p.1143-5.

Reviewed by Dr Len Brake

Review: Google is useful to get a printout for patient information. These authors decided to check Google out as a diagnostic tool when one of them started to explain the cause of a 16-year-old's acute subclavian vein thrombosis to a family. The father of the patient blurted out, *'But of course he has Paget-von Schrotter syndrome'*, and proceeded to give a tutorial on the cause of the thrombosis and outlined the correct treatment. (Editorial attached)

Comment: This is an interesting and light-hearted article, which highlights a speedy and surprisingly accurate way to get a list of differential diagnoses for a group of signs and symptoms.

Musculoskeletal System

27–145 A prospective, randomized clinical investigation of the treatment of first-time ankle sprains

Beynnon BD, Renstrom PA, Haugh L, et al. Am J Sports Med. September 2006. Vol.34. No.9. p.1401-12.

Reviewed by Dr Len Brake

Review: Two hundred and twelve young adults took part in the RCT when they had their first ankle sprain. In broad terms the simpler injuries did best with a stirrup brace and an

elastic wrap; the more severe injuries had immobilisation in a cast for 10 days in addition to the above. These treatments meant earlier mobilisation but at six months there were no differences in ankle function or movement between any of the treatment groups for any severity of ankle injury!

Neurology

27–146 Prognosis of migraine headaches in adolescents: A 10-year follow-up study

Monastero R, Camarda C, Pipia C, et al. Neurology. 24 October 2006. Vol.67. No.8. p.1353-6.

Reviewed by Dr Jim Vause

Review: An Italian study, which looked at the long-term outcome of migraine headaches in fifty-five adolescents, found that 41.8% had persistent migraine, 38.2% had experienced remission, and 20.0% transformed to tension-type headache. Only migraine without aura persisted in the same IHS code after 10 years, whereas migrainous disorder and nonclassifiable headache did not. The family history of migraine significantly predicted the 10-year persistence of migraine headaches.

Comment: Migraine headaches in adolescents have a favorable long-term prognosis but familial disposition for migraine predicted a poorer outcome, especially in subjects with migraine without aura.

Nutrition

27–147 Low-carbohydrate-diet score and the risk of coronary heart disease in women

Halton TL, Willett WC, Liu S, et al. N Engl J Med. 9 November 2006. Vol.355. No.19. p.1991-2002.

Reviewed by Dr Raina Elley

Review: Low carbohydrate diets (i.e. relatively higher proportions of fat and/or protein) were not associated with increased risk of coronary heart disease (CHD) when compared with diets with higher proportions of carbohydrates. A cohort of over 80 000 women from the Nurses' Health Study was followed up for 20 years and their diets analysed. In fact, if protein and fat were mainly from vegetables sources, low carbohydrate diets were associated with a lower risk of CHD. A high glycaemic load was associated with a higher risk of CHD. The analyses were adjusted for several risk factors like gender, age, smoking, hypertension, BMI, family history of CHD and physical activity.

Comment: This is reassuring because there was a concern that such 'low carbohydrate' diets as the Atkins diet, could adversely affect lipid profile and increase risk of CHD. However, RCTs are needed to confirm these findings, as there may be unknown confounding factors that have not been controlled for (remember HRT). Also RCTs to determine the effects and risks of these diets in certain populations are needed (e.g. in diabetes).

27–148 A self-regulation program for maintenance of weight loss

Wing RR, Tate DF, Gorin AA, et al. N Engl J Med. 12 October 2006. Vol.355. No.15. p.1563-71.

Reviewed by Dr Raina Elley

Review: In those who have lost weight, a self-regulation programme delivered face-to-face, with daily weighs is more effective at preventing weight gain than quarterly newsletters (control). When the same self-regulation programme was delivered via Internet it did not prevent weight gain compared with control. This was a three-armed RCT with 18-month follow-up.

Comment: There is something about the face-to-face contact that makes the difference.

Nutritional and Metabolic Diseases

27–149 Sex differences in the relationships between BMI, WHR and incidence of cardiovascular disease: a population-based cohort study

Li C, Engström G, Hedblad B, et al. Int J Obes. December 2006. Vol.30. No.12. p.1775-81.

Reviewed by Dr Anne-Thea McGill

Review: This large cohort (longitudinal) study used anthropometry (no lab measurements) to gauge the best predictor of CVD (IHD, CVA and CVD death) and compared men and women. It only used data for participants with all variables measured and applied comprehensive correcting for lifestyle factors. High waist:hip ratio (W:HR) added prognostic information on the CVD risk in women (10% intra-abdominal fat) at all levels of BMI. A similar relationship was observed only in men (21% intra-abdominal fat) with normal weight.

Comment: Measuring the hip circumference is back! This study concurs with a number of other studies – higher hip and thigh fat in many women is protective from CVD even with high BMI. In men it appears to be useful in men with BMI<25. The medical profession needs to categorise CVD risk better – all people with a high W:HR are at risk. Functional and psychological, but not intensive metabolic, screening in those low W:HR may be helpful.

27–150 Overweight, obesity, and mortality in a large prospective cohort of persons 50 to 71 years old

Adams KF, Schatzkin A, Harris TB, et al. N Engl J Med. 24 August 2006. Vol.355. No.8. p.763-78.

Reviewed by Dr Raina Elley

Review: Being overweight in mid-life increases your risk of death by 20–40%. Being obese increases the risk by two to three times. This was a 10-year prospective cohort study of over half a million middle-aged adults (50–71 years at enrolment), as part of the US National Institutes of Health-AARP study. Smokers were excluded from the main analysis. Analyses were controlled for education, ethnicity, alcohol consumption, physical activity and allowance was made for chronic illness.

Comment: These seem intuitive results and the association between obesity and increased risk of death has been made before. However, just being overweight (BMI 25–29) has not been shown to be predictive of early death previously. In fact, I remember an article a year or so ago in *NEJM* from the large NHANEs database that showed no increase in risk of death in those overweight compared with normal weight.

Ophthalmology

27-151 Misdiagnosis of angle closure glaucoma

Gordon-Bennett P, Ung T, Stephenson C, et al. BMJ. 2 December 2006. Vol.333. No.7579. p.1157-8.
Reviewed by Dr Len Brake

Review: This 'Lesson of the Week' has three case reports where there were serious problems in misdiagnosis of glaucoma. The article highlights the importance of a need for awareness of angle closure glaucoma and reminds us of the signs and symptoms to watch out for.

Comment: The discussion details a summary of the pathophysiology and treatment.

Orthopaedics

27-152 Surgical vs nonoperative treatment for lumbar disk herniation: The Spine Patient Outcomes Research Trial (SPORT): a randomized trial

Weinstein JN, Tosteson TD, Lurie JD, et al. JAMA. 22/29 November 2006. Vol.296. No.20. p.2441-50.
Reviewed by Dr Len Brake

Review: I will make a prediction. It will not be wrong. In a few short years, the groups of surgeries for low back pain and the surgeries to 'repair' rotator cuff tears will both go the way of the internal mammary artery implantation treatment for angina. That is 'down the gurgler'. The evidence for this is both anecdotal and personal observation over the past 30 years. This is a trial called SPORT (Spine Patient Outcomes Research Trial), which failed because 30% of the patients randomised to no surgical treatment had surgery and a group of the surgically randomised people decided against going 'under the knife'.

Comment: Anyway the outcome is a close photo finish, i.e. in the surgery vs non-surgery fight there is no clear winner. It would take a sham controlled trial for a true indication of any benefits of lumbar discectomy. See also 27-153, 27-154 and 27-155.

27-153 Surgical vs nonoperative treatment for lumbar disk herniation: the Spine Patient Outcomes Research Trial (SPORT) observational cohort

Weinstein JN, Lurie JD, Tosteson TD, et al. JAMA. 22/29 November 2006. Vol.296. No.20. p.2451-9.
Reviewed by Dr Len Brake

Review: See 27-152, 27-154 and 27-155.

27-154 Intrepreting surgical trials with subjective outcomes: avoiding UnSPORTsmanlike conduct

Flum DR. JAMA. 22/29 November 2006. Vol.296. No.20. p.2483-5.
Reviewed by Dr Len Brake

Review: See 27-152, 27-153 and 27-155.

27-155 Surgical treatment of lumbar disk disorders

Carragee E. JAMA. 22/29 November 2006. Vol.296. No.20. p.2485-7.
Reviewed by Dr Len Brake

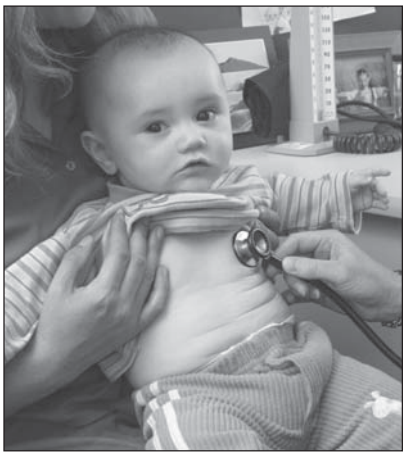
Review: See 27-152, 27-153 and 27-154.

Paediatrics

27-156 What is the best treatment for infants with colic?

Crotteau CA, Wright ST. J Fam Pract. July 2006. Vol.55. No.7. p.634-6.
Reviewed by Dr Bruce Adlam

Review: Evidence-based answer: Infantile colic, defined as excessive crying in an otherwise healthy baby,



is a distressing phenomenon, but there is little evidence to support the many treatments offered. Several small studies report some benefit from use of a hypoallergenic (protein hydrolysate) formula, maternal diet adjustment (focusing on a low-allergen diet), and reduced stimulation of the infant. While dicyclomine has been shown to be effective for colic, there are significant concerns about its safety, and the manufacturer has contraindicated its use in this population. An herbal tea containing chamomile, vervain, licorice, fennel, and balm-mint was also effective in a small RCT, but the volume necessary for treatment limits its usefulness (strength of recommendation: B, inconsistent or limited-quality patient-oriented evidence). The one proven treatment is time, as this behaviour tends to dissipate by six months of age.

Comment: Obviously late night rides in the car, walks around the block were not considered worthwhile studying. It's just as well my first-born reached her first birthday before concerns regarding dicyclomine emerged.

Palliative Care

27-157 Anger in palliative care: a clinical approach

Philip J, Gold M, Schwarz M, et al. Intern Med J. January 2007. Vol.37. No.1. p.49-55.
Reviewed by Dr Helen Moriarty

Review: This paper reports on a qualitative project researching clinical experience of anger in the palliative care setting. The article describes findings under thematic titles. Themes were derived from nine focus groups involving 45 multidisciplinary health professionals. A seven-step approach is drawn up to deal with anger.
Comment: The seven steps are disappointing after an interesting build up of focus group citations. The seven steps are logical and intuitive, and lend themselves to the 'so what' criticism.

27-158 Defining limits in care of terminally ill patients

Braun UK, Beyth RJ, Ford ME, et al. BMJ. 3 February 2007. Vol.334. No.7587. p.239-41.
Reviewed by Dr Peter Woolford
Review: This is a simple review of the doctor's role in the terminal care phase, particularly looking at the role of medical intervention and how to pitch the level for the patient, the family and the doctor.
Comment: This review is hospital based, but still the discussion is appropriate for general practice. In general practice in New Zealand we have a further responsibility to liaise with secondary care doctors in terms of guiding what is appropriate treatment based on our relationship with patients and families.

27-159 Terminally-ill people living alone without a caregiver: an Australian national scoping study of palliative care needs

Aoun S, Kristjanson LJ, Currow D, et al. Palliative Medicine. January 2007. Vol.21. No.1. p.29-34.
Reviewed by Dr Peter Woolford
Review: An increasing number of people with a terminal illness live alone and have no primary caregiver. This study attempts to identify key issues to support this group of patients. The main recommendations were: a 24-hour palliative care service (including: a night sitting service, after hours support service, pool of volunteers and paid caregivers), funded palliative care packages, support packages for in-house respite and funded alert link systems
Comment: Not a bad wish list!

27-160 A retrospective review of place of death of palliative care patients in regional north Queensland

Howat A,Veitch C, Cairns W. Palliative Medicine. January 2007. Vol.21. No.1. p.41-7.
Reviewed by Dr Peter Woolford
Review: Only 19% of 270 patients under the care of the specialist palliative care service in Townsville died at home in 2004!
Comment: This was a retrospective study and the authors quite rightly say that a further prospective study with an emphasis on GP involvement with palliative care is warranted. Other studies have shown that caring doctor involvement at home is a very powerful predictor of home death.

27-161 Improving the delivery of palliative care in general practice: an evaluation of the first phase of the Gold Standards Framework

Thomas K, Noble B. Palliative Medicine. January 2007. Vol.21. No.1. p.49-53.
Reviewed by Dr Peter Woolford
Review: Most cancer patients want to die at home if possible and if well supported. However only 25% do. The Gold Standards Framework (www.goldstandardsframework.nhs.uk) has been developed in the UK as a tool to help general practice provide care for patients in their homes, allowing patients to fulfil their wish.
Comment: I have not had a critical look at the GSF, but understanding the importance of general practice in the delivery of care, it is an attempt to support general practice in the delivery of this care. Another British endeavour, the Liverpool Care Pathway (LCP) is a template for care of patients in the last 48 hours of life. This is already being trialled in New Zealand. We will hear more of both.

27-162 Ethical issues arising from the requirement to provide written information in palliative care

Plu I, Moutel G, Purssell-Francois I, et al. Palliative Medicine. January 2007. Vol.21. No.1. p.55-7.
Reviewed by Dr Peter Woolford
Review: In the French medical system it is a legal requirement that patients or family sign an information and consent form when entering the care of the palliative care team. This paper discusses issues around the timing of this consent.
Comment: We all have had patients who chose not to accept 'palliative' or 'hospice' care because they are not ready to face their death. The interesting piece of information here is not that this was an issue but that the requirement *'may also make it impossible to hide the patient's condition for his or her own good when the doctor considers that he or she is not ready to hear such information which is contrary to the French code or deontology'.* A clear cultural difference!

Pharmacology

27-163 Management of grapefruit-drug interactions

Stump AL, Mayo T, Blum A. Am Fam Physician. 15 August 2006. Vol.74. No.4. p.605-8, 611.
Reviewed by Dr Andrea Steinberg
Review: The mechanism of this interaction is well defined, through inhibition of intestinal cytochrome P450 3A4 system. This occurs within four hours of ingestion of grapefruit, and may persist for up to 72 hours. Therefore separating the times of medication administration and grapefruit consumption is not a plausible solution. Due to genetic polymorphism, persons have varying amounts of intestinal CYP 3A4; consequently, the extent of an interaction is not predictable from patient to patient. Prominent medications known to interact with grapefruit include statins, antiarrhythmic agents, immunosuppressive agents, and calcium channel blockers. This article presents a comprehensive list of other medications that may interact, and the degree of

clinical significance of the interaction. (Patient page attached)
Comment: An interesting, detailed review, important to keep in mind when prescribing commonly used medication in primary care such as statins, felodipine, and amiodarone.

27-164 Management of common opioid-induced adverse effects

Swegle JM, Logemann C. Am Fam Physician. 15 October 2006. Vol.74. No.8. p.1347-54.
Reviewed by Dr Andrea Steinberg
Review: A comprehensive, in-depth review of aetiology and pharmacological management of common side-effects. Nausea occurs in approximately 25 per cent of patients; prophylactic measures may not be required. Patients who do develop nausea will require antiemetic treatment with an antipsychotic, prokinetic agent, or serotonin antagonist. Understanding the mechanism for opioid-induced nausea will aid in the selection of appropriate agents. Constipation is considered an expected side effect with chronic opioid use. Physicians should minimise the development of constipation using prophylactic measures. Monotherapy with stool softeners often is not effective; a stool softener combined with a stimulant laxative is preferred. Sedation and cognitive changes occur with initiation of therapy or dose escalation. Underlying disease states or other centrally acting medications often will compound the opioid's adverse effects. Minimising unnecessary medications and judicious use of stimulants and antipsychotics are used to manage the central nervous system side effects. Pruritus may develop, but it is generally not considered an allergic reaction. Antihistamines are the preferred management option should pharmacotherapy treatment be required.
Comment: As well as the medical therapies discussed comprehensively in this article, strategies to minimise these adverse effects may also include dose reduction, opioid rotation, and changing the route of administration.

27-165 Approach to managing patients with sulfa allergy: Use of antibiotic and nonantibiotic sulfonamides

Ponka D. Can Fam Physician Med Fam Can. November 2006. Vol.52. p.1434-8.
Reviewed by Dr Mike Lyons
Review: Cross reactivity between sulphur antibiotics and non antibiotics is rare but may affect the pharmacological and clinical management of patients with a sulphur allergy.
Comment: If you already appreciate the relevance of Frusemide, Hydrochlorothiazide, Indapamide, Gliclazide, Probenecid, Celecoxib, Sotolol and Sumatriptan to sulphur allergy you do not need to read the article!

Preventive Medicine and Screening

27-166 HIV postexposure prophylaxis: Who should get it?

Campos-Outcalt D. J Fam Pract. July 2006. Vol.55. No.7. p.600-4.
Reviewed by Dr Bruce Adlam
Review: In most cases, HIV post exposure prophylaxis (PEP) is given only to health care workers if the settings make exposure to HIV-infected persons likely. Otherwise, it is usually deemed unnecessary. However, a decision for or against PEP is complicated and this article distils the Centers for Disease Control and Prevention's most recent guidance. It acknowledges the exposure risk is frequently incomplete, the risk of infection is usually low, the degree of protection offered by PEP is not fully defined, and the potential for side effects from the medications is significant.
Comment: Bottom line is if you're unsure, start patients on a PEP regimen while the situation is sorted out.

Procedures and Techniques

27-167 Practice tips: Knee joint injections and aspirations: The triangle technique

Lockman LE. Can Fam Physician Med Fam Can. November 2006. Vol.52. p.1403-44.
Reviewed by Dr Mike Lyons
Review: A two-page article from Practice Tips. Describes technique with patient sitting and knee flexed to 90 degrees. A lateral approach between patella and femur is outlined introducing the needle parallel to the middle facet of the patella. An accuracy rate of 90% is purported.
Comment: An alternative to consider to the more traditional medial approach to a patient lying down with knee extended.

Psychiatry and Psychology

27-168 Entering menopause increases the risk of first episode depression

Fugate Woods N. Evid Based Ment Health. November 2006. Vol.9. No.4. p.109.
Reviewed by Dr Tannis Laidlaw
Review: These two papers published in the same issue present evidence that women with no previous history of major depression are significantly more likely to suffer depressive symptoms and clinical depression when in the menopausal transition compared to pre-menopause. (Original article reviewed: Arch Gen Psychiatry 206, 63: 385-90) See also 27-169.
Comment: Bromberger comments on the Freeman paper that clinicians need to be aware of an increased vulnerability to a first onset of depression at menopausal transition. Fugate Woods comments on the Cohen paper that women in their study were more than twice as likely to suffer depression at menopausal transition than pre-menopausal women. This is consistent with the stress-diathesis model of depression where the change in hormonal milieu may increase vulnerability for depression when coupled with negative life events.

27-169 The menopausal transition increases the risk of depressive symptoms and depression diagnosis in women without a history of depression

Bromberger JT. Evid Based Ment Health. November 2006. Vol.9. No.4. p.110.
Reviewed by Dr Tannis Laidlaw

Review: See 27-168 (Original article reviewed: Arch Gen Psychiatry 2006, 63: 375-82).

27–170 Effect of chronic diseases and associated psychological distress on health-related quality of life

Keles H, Ekici A, Bulcun E, et al. Intern Med J. January 2007. Vol.37. No.1. p.6-11.
Reviewed by Dr Helen Moriarty

Review: A survey of parents and grandparents associated with children at seven primary schools where they completed health symptom screening questionnaires, HADS (Hospital Anxiety and Depression Scale) and SF-12. A 91.6% response rate of all possible parents and grandparents was achieved, with 4605 respondents. Findings reinforced that chronic disease reduces quality of life, and physical and mental functioning decline as chronic disease burden increases. The authors recommend detection of psychological distress and treatment of that as well as chronic disease comorbidites.

Comment: This paper called for an enormous amount of data entry and analysis to come up with a result that most of us would consider intuitive. Interestingly, the paper declares 'funding: none'. Which raises questions about the author transparency, since handling of 4605 paper-based questionnaires must have consumed considerable time and other resources. The paper does not comment on the 'success' and ethical issues involved in school-based surveys, and use of the children's own teachers to ensure return of questionnaires. The study was based in Turkey where cultural expectations for conformity and privacy may have impacted on the response rate.

27–171 Alternatives similar for depression treatment failures

J Fam Pract. July 2006. Vol.55. No.7. p.574.
Reviewed by Dr Bruce Adlam

Review: Bupropion, sertraline, and venlafaxine are equally effective at inducing remission or response in patients with persistent symptoms of depression despite initial treatment with citalopram. Most patients will not go into remission though, and this study lacked a placebo control group (LOE: 1b). (Original article reviewed: N Engl J Med 2006; 354: 1231-42).

Comment: Only venlafaxine is available on the NZ pharmaceutical schedule.

27–172 Does every allusion to possible suicide require the same response?

Raue PJ, Brown EL, Meyers BS, et al. J Fam Pract. July 2006. Vol.55. No.7. p.605-12.
Reviewed by Dr Bruce Adlam

Review: Practice recommendations: (a) Assess patients with major depression or substance abuse for suicide ideation, as they are at elevated risk for self-harm (B). (b) Severity of suicide ideation is associated with suicide risk. Its assessment, therefore, should proceed sequentially from passive to active suicide ideation, to a specific detailed plan, including intention to harm oneself, reasons for living, and impulse control (B). (c) Primary care patients at mild to moderate risk for suicide can be effectively treated in primary care settings (B); however, patients at high risk should be referred to mental health specialists given their need for intensive treatments and frequent monitoring (C). (d) Eleven studies of completed suicides found that, on average, 23% of victims aged 35 and younger and 58% of victims aged 55 and older visited a general physician in the month preceding suicide. These rates substantially exceed those seen in specialty mental health services. Chart reviews revealed that 60% of patient visits by those who committed suicide included psychiatric components, such as depression or worry.

Comment: Key message for me in this item is that suicidal ideation is not just present or not present. It's part of a continuum and likely to change due to circumstance, medication (i.e. controversy over the first 10 days of SSRI therapy), or changes in dosages, and requires follow-up inquiry.

27–173 Effectiveness of atypical antipsychotic drugs in patients with Alzheimer's disease

Schneider LS, Tariot NP, Dagerman KS, et al. N Engl J Med. 12 October 2006. Vol.355. No.15. p.1525-38.
Reviewed by Dr Raina Elley

Review: This RCT of 421 patients with Alzheimer's disease and psychosis, aggression or agitation compared treatments of olanzipine, quetiapine, risperidone and placebo. They used the median time to discontinuation as the outcome, as it integrates real-life patient, caregiver and clinician judgements about efficacy, side-effects and tolerability. Although the median time to discontinuation due to lack of efficacy favoured olanzipine (22.1 weeks) and respiridone (26.7 weeks) compared with quetiapine (9.1 weeks) and placebo (9.0 weeks), there was no difference in median time to discontinuation for any reason (respectively 8.1, 7.4, 5.3 and 8.0 weeks). There was also difference between the groups in effect on Clinical Impression of Change (CGIC) scale at 12 weeks.

Comment: Although it would appear that two of the atypical antipsychotics were more effective at controlling symptoms, because of their safety or tolerability problems, they were used no longer than the placebo. Again, this reminds us that proven benefit has to be weighed against potential harm.

Rheumatic Diseases

27–174 Polymyalgia rheumatica and giant cell arteritis

Unwin B, Gilliland W. Am Fam Physician. 1 November 2006. Vol.74. No.9. p.1557-8.
Reviewed by Dr Andrea Steinberg

Review: This review of a most important condition, discusses the well-known features as well as less common presentations, such as dry cough, choking sensation, fever of

unknown origin, upper- and lower-extremity claudication and neurologic manifestations (mononeuropathies, peripheral polyneuropathies, and, rarely, transient ischaemic attacks or strokes). The Polymyalgia Rheumatica Activity Scale (PMR-AS) is discussed, which uses five variables to monitor and adjust therapy: a visual analogue scale for pain from the patient, a visual analogue scale for the physician's assessment, C-reactive protein level, morning stiffness time (measured in minutes), and assessment of the ability to elevate the upper limbs. (Patient page attached.)

Comment: It is most important to be aware of the corticosteroid-associated complications. That is osteoporosis, corticosteroid myopathy, bruising, emotional symptoms (e.g. insomnia, restlessness, hypomania, depression), hypertension, diabetes, elevated cholesterol, and fluid retention. GCA and PMR are not associated with increased mortality.

Sports and Exercise Medicine

27–175 Cox-2 inhibitors in sports medicine: utility and controversy

Buvanendran A, Reuben SS. Br J Sports Med. 1 November 2006. Vol.40. No.11. p.895-6.

Reviewed by Dr Chris Milne

Review: The main advantage of cox-2 agents over traditional NSAIDS is their better GI safety profile. In addition these authors state that they can be administered pre-emptively to surgical patients without the added risk of perioperative bleeding. They also discuss results of the ADAPT trial which compared use of celecoxib and naproxen in therapeutic doses, and found that naproxen had a statistically significant increase in cardiovascular risk, but celecoxib did not.

Comment: Cox-2 agents have a definite place in treatment of sports injuries, and previous concerns re adverse cardiovascular risk may have been overstated.

27–176 Decline in large elastic artery compliance with age: a therapeutic target for habitual exercise

Gates PE, Seals DR. Br J Sports Med. 1 November 2006. Vol.40. No.11. p.897-9.

Reviewed by Dr Chris Milne

Review: As we age our tissues get less elastic. In the walls of arteries, this leads to increasing systolic blood pressure. However, recent trials have shown that after as little as three months of aerobic exercise middle-aged men can increase their carotid artery compliance by about 25%. Literally, one can turn back the clock. Unfortunately studies of weight training show the opposite – the arterial walls become stiffer (less compliant).

Comment: Yet another potential benefit for aerobic exercise has been discovered.

27–177 Hyperinsulinaemia, hyperaminoacidaemia and post-exercise muscle anabolism: the search for the optimal recovery drink

Manninen AH. Br J Sports Med. 1 November 2006. Vol.40. No.11. p.900-5.

Reviewed by Dr Chris Milne

Review: Both increased insulin and an adequate supply of amino acids are needed to maximise muscle protein anabolism. This paper states that by adding protein hydrolysates and leucine to sports drinks, there could be increased protein deposition in muscle after appropriate weight training.

Comment: As the author says, you can have your protein shake and drink it too. Very detailed paper with 82 references (enough to keep your obsessional body-builder patient very well informed).

27–178 Sex differences in baseline neuropsychological function and concussion symptoms of collegiate athletes

Covassin T, Swanik CB, Sachs M, et al. Br J Sports Med. 1 November 2006. Vol.40. No.11. p.923-7.

Reviewed by Dr Chris Milne

Review: These authors have shown that male and female athletes differ on baseline tests of visual and verbal memory. Female athletes performed significantly better on baseline verbal memory compared to male athletes. For visual memory, the reverse was true. This confirms previous suspicions – male and female brains do have some subtle differences!

Comment: These data serve to emphasise the importance of a baseline test, as then the athlete serves as their own control when reassessed after a head injury. If comparing the athlete with normative data, this data should ideally be gender-specific.

27–179 Use of the one-legged hyperextension test and magnetic resonance imaging in the diagnosis of active spondylolysis

Masci L, Pike J, Malara F, et al. Br J Sports Med. 1 November 2006. Vol.40. No.11. p.940-6.

Reviewed by Dr Chris Milne

Review: Stress fractures of the pars interarticularis are very common in certain sports (e.g. cricket (fast bowlers), gymnastics and tennis players). There are very few specific clinical tests that have been shown to be of value. The authors compared the clinical test of pain on one-legged hyperextension with results on imaging performed on 71 athletes from a range of sports. The hyperextension test was found to be a poor indicator of active spondylolysis and should not be used as a diagnostic tool.

Comment: Like all clinical tests, this one has been found to have its limitations. If the history and other clinical findings are suspicious, the best investigations remain a bone scan with SPECT, followed by CT scan on those athletes with a hot spot on their bone scan.

27–180 What is sports and exercise medicine?

McCrory P. Br J Sports Med. 1 December 2006. Vol.40. No.12. p.955-7.

Reviewed by Dr Chris Milne

Review: Over the past few years, sports medicine has morphed into sports and exercise medicine. This reflects the growth in knowledge regarding exercise as both prevention and treatment of 'lifestyle diseases' of inactivity such as type 2 diabetes. This article proposes a new definition of sport and exercise medicine.
Comment: Useful commentary on the evolution of this discipline, set against a backdrop of the differing states of health where sports and exercise medicine can contribute to wellbeing.

27–181 Results of arthroscopic debridement for osteochondritis dissecans of the elbow

Rahusen F Th G, Brinkman J-M, Eygendaal D. Br J Sports Med. 1 December 2006. Vol.40. No.12. p.966-9.
Reviewed by Dr Chris Milne
Review: Osteochondritis dissecans (OCD) is an overuse injury, found in athletes. Occasionally, defects can be seen on plain x-rays, but MRI is more sensitive. For severe lesions, arthroscopic debridement is effective. It seems to offer more benefits for older patients.
Comment: Arthroscopic treatment of elbow problems is also of benefit for those patients who have early degenerative change related to heavy manual work. It can help improve the range of extension in such patients.

27–182 Trampoline injuries

Nysted M, Drogset JO. Br J Sports Med. 1 December 2006. Vol.40. No.12. p.984-7.
Reviewed by Dr Chris Milne
Review: This Norwegian study examines 556 patients with trampolining injuries. Fifty-three per cent of these were related to an awkward landing on the trampoline and 22% followed a fall off the trampoline. Thirty-six per cent of injuries resulted in a fracture, with elbow, wrist and ankle injuries being the most common.
Comment: Serious injuries can occur after falling off a trampoline, with younger children (under 10 years) being at greater risk. Important guidelines recommend that only one participant should use the trampoline at a time and adult supervision is frequently recommended (but less commonly practised).

27–183 The validation of a novel activity monitor in the measurement of posture and motion during everyday activities

Grant PM, Ryan CG, Tigbe WW, et al. Br J Sports Med. 1 December 2006. Vol.40. No.12. p.992-7.
Reviewed by Dr Chris Milne
Review: In recent years, there has been an increasing emphasis on habitual physical activity to ward off 'lifestyle diseases'. These workers from Glasgow report on a credit card sized monitor worn on the anterior aspect of the thigh. The validity and reliability of this device was established, and it was able to record posture and positional change.
Comment: The only criticism I would have is that they did not offer any comparison with the already widely available pedometer.

27–184 High school rugby players' understanding of concussion and return to play guidelines

Sye G, Sullivan SJ, McCrory P. Br J Sports Med. 1 December 2006. Vol.40. No.12. p.1003-5.
Reviewed by Dr Chris Milne
Review: This New Zealand based survey of 477 male high school rugby players found that about half of them were aware of concussion guidelines, and 60% identified the mandated stand down period. However, 27% of players felt that a player with suspected concussion should play in an important game such as a final.
Comment: Clearly some, but not all of the messages about concussion are getting through to our high school players. If you as a GP have doubts about a player returning to play, referral to a sports physician or neurologist should be considered.

Vaccinations and Vaccines

27–185 Should HPV vaccines be mandatory for all adolescents

Lancet. 7 October 2006. Vol.368. No.9543. p.1212.
Reviewed by Dr Tony Hanne
Review: The new vaccine against HPV types 16 and 18, Gardisil, has now been licensed in both the USA and Europe. The state of Michigan has passed legislation making the vaccine mandatory for all girls aged 11 and 12. Vigorous discussion is going on as to whether the same course should be followed in other American states and in Europe. Debate is also centred around whether boys should likewise be required to be immunised to increase herd immunity as happened with rubella vaccination when it was extended to males. There is also the vexed question of who will pay for an expensive vaccine.
Comment: The hope is that in time this vaccine will eliminate cervical cancer as well as genital warts and anal cancer. The mind boggles at the prospect of the furious protests, which would arise in New Zealand if this or any immunisation was ever legally compelled, particularly as HPV is one disease which can be avoided by lifestyle choice. This brief article is worth reading just to generate thought on what will be an impassioned debate.

Virus Diseases

27–186 Erythema multiforme

Lamoreux MR, Sternbach MR, Hsu WT. Am Fam Physician. 1 December 2006. Vol.74. No.11. p.1883-8.
Reviewed by Dr Andrea Steinberg
Review: Herpes simplex virus (HSV) is the most commonly identified aetiology of this hypersensitivity reaction, accounting for more than 50 per cent of cases. Mycoplasma pneumoniae (especially in children) and fungal infections are other less common infectious causes. The medications most often associated with ery-

thema multiforme are barbiturates, hydantoins, nonsteroidal anti- inflammatory drugs, penicillins, phenothiazines, and sulfonamides. Some vaccines (diphtheria-tetanus, hepatitis B), other viruses (varicella zoster virus, hepatitis C, CMV and HIV), and other medications (candesartan, rofecoxib, metformin, ciprofloxacin) are less common causes. Recurrent erythema multiforme often is secondary to HSV-1 and -2 reactivation, although the HSV may be clinically silent. The pathogenesis of herpes-associated erythema multiforme has been well studied and is consistent with a delayed-type hypersensitivity reaction. Mild cases of erythema multiforme do not require treatment. Oral antihistamines and topical steroids may be used to provide symptom relief. In patients with coexisting or recent HSV infection, early treatment with oral acyclovir may lessen the number and duration of cutaneous lesions. Topical acyclovir applied to preceding HSV lesions does not prevent herpes-associated erythema multiforme. Prednisone may be used in patients with many lesions at dosages of 40 to 80 mg per day for one to two weeks then tapered rapidly. However, its use is controversial, as there have been no controlled studies of prednisone's effectiveness, and its use in patients with herpes-associated erythema multiforme may lower the patient's resistance to HSV and promote recurrent HSV infection followed by recurrent erythema multiforme. Recurrent erythema multiforme may be treated with continuous oral acyclovir (400 mg two times per day) even if HSV is not an obvious precipitating factor. Once the patient is recurrence free for four months, the dosage may be decreased and eventually the drug may be discontinued.

Comment: Patients with recurrent erythema multiforme despite the use of suppressive antiviral therapy should be referred to a dermatologist for further treatment.

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