Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Am Fam Physician*
Aust Fam Physician*
BMJ*
Br J Sports Med*
Complement Ther Med*
Drug Alcohol Rev*
Emerg Med Australas*
Evid Based Ment Health*
Health Psychol*
Intern Med J*
J Fam Pract*
J pain Symptom Manage*
Lancet*
Obes Res Clin Prac*
Obstet Gynecol*
Pain*
Palliat Med*
Pediatrics*
Prim Care*
Sci Am*
*Journals indexed in Medline

Acupuncture

28–081 The management of cancer-related fatigue after chemotherapy with acupuncture and acupressure: a randomised controlled trial

Molassiotis A, Sylt P, Diggins H. Complement Ther Med. December 2007. Vol.15. No.4. p.228-37.

Reviewed by Dr Alex Chan

Review: In this trial, participants were randomised to one of three treatment streams: (1) needle acupuncture 'energy related points' LI-4, ST-36, SP-6 for 20 minutes bilaterally three times per week for two weeks; (2) tonifying acupressure to the same points one minute daily for two weeks; or (3) acupressure to 'non-energy related points' LI-12, GB-33, BL-61. The third group was considered as the sham control group. The Multidimensional Fatigue Inventory (MFI) was used as a tool for measuring changes in the various aspects of experience related to fatigue. Acupuncture and acupressure were found to significantly improve the participants' general fatigue, physical fatigue, activity, and motivation though they had no effect on mental fatigue as assessed by the MFI.

Comment: The final assessment should really be performed after a longer course of treatment. One could also argue that a major acupoint, e.g. LR-3, from the Liver meridian for detoxification should have been included in the prescription used.

28–082 Neuroendocrinological effects of acupuncture treatment in patients with irritable bowel syndrome.

Schneider A, Weiland C, Enck P, et al. Complement Ther Med. December 2007. Vol.15. No.4. p.255-63.

Reviewed by Dr Alex Chan

Review: This was a secondary analysis of a randomised, controlled study on acupuncture treatment of irritable bowel syndrome. The first part of the same study had previously reported no significant group difference in quality of life improvement after treatment between real or sham acupuncture groups. In this study, quality of life, salivary cortisol and autonomic nervous function before and after the treatments were measured and analysed. Quality of life was found to be increased in both groups with no group difference. However, salivary cortisol decreased in both groups, but more so in the real acupuncture group. Also, parasympathetic tone was found to be increased in the real acupuncture group but not in the sham acupuncture group.

Comment: Our body is certainly more complex than what we know. Sham acupuncture probably affects the body using different physiological pathways.

28-083 Ear acupuncture for hot flushes – the perceptions of women with breast cancer

Walker G, De Valois B, Davies R, et al. Complement Ther Med. November 2007. Vol.13. No.4. p.250-7.
Reviewed by Dr Alex Chan
Review: The effect of ear acupuncture on hot flushes and night sweats in women on adjuvant hormonal therapy for breast cancer was assessed in this qualitative research. Eight treatment sessions were delivered in small group clinics. Following the treatments, participants were invited to take part in three focus groups to discuss a range of topics. The authors attempted to explore from the discussions the reasons of the participants for joining the study, their experience of having ear acupuncture, the results of the treatment, and their experience of group treatments. The data were analysed using grounded techniques.
Comment: A very interesting and informative research paper, different from the usual quantitative studies, revealing the inner thinking and personal experience of the participants. Well worth reading!

28-084 Laser acupuncture in children with headache: a double-blind, randomized, bicenter, placebo-controlled trial

Gottschling S, Meyer S, Gribova I, et al. Pain. 2007. Vol.in press.
Reviewed by Dr Alex Chan
Review: Low level laser (30mW, 830 nm, 30s) acupuncture once a week for four weeks, using both body and auricular points based on Traditional Chinese Medicine theory, was found to significantly reduce the frequency and intensity of headaches comparing to placebo laser acupuncture in children with chronic tension or migrainous headaches in this prospective, randomised, double-blind, placebo-controlled trial. The mean number of headaches decreased by 6.4 days per month in the real acupuncture group from the time of treatment and persisted up to end of follow-up at 16 weeks from randomisation into treatment groups.
Comment: It is interesting to note that the number of headaches in the placebo laser acupuncture group only decreased by one day per month during treatment but this little benefit disappeared in the follow-up immediately after cessation of treatment. Placebo arrangement in laser acupuncture is clearly much simpler than needle acupuncture.

Adolescent Health

28-085 Contraception and adolescents

Committee on Adolescence. Pediatrics. November 2007. Vol.120. No.5. p.1135-48.
Reviewed by Dr Jocelyn Tracey
Review: A state of the art type article, that covers both issues around counselling adolescents in contraception as well as detailed information on the various methods (some not available in NZ).
Comment: Worth reading for an update on contraception methods, especially when used by adolescents.

28-086 Guidelines for adolescent depression in primary care (GLAD-PC): I. identification, assessment, and initial management

Zuckerbrot RA, Cheung AH, Jensen PS, et al. Pediatrics. November 2007. Vol.120. No.5. p.e1299-312.
Reviewed by Dr Jocelyn Tracey
Review: These both provide a very good review of the literature and guideline statements around assessment and management, along with flowcharts and summaries.
Comment: Quite long and detailed, but some helpful stuff in there, especially around need for follow-up and use of medications in the second article (see 28-087).

28-087 Guidelines for adolescent depression in primary care (GLAD-PC): II. treatment and ongoing management

Cheung AH, Zuckerbrot RA, Jensen PS, et al. Pediatrics. November 2007. Vol.120. No.5. p.e1313-26.
Reviewed by Dr Jocelyn Tracey
Review: See 28-086.

Asthma

28-088 PRN steroids are as good as – or better – than daily dosing for asthma

J Fam Pract. August 2007. Vol.56. No.8. p.620.
Reviewed by Dr Bruce Adlam
Review: For patients with mild persistent asthma, symptoms and exacerbations were controlled just as well using a combination of beclomethasone 250mcg plus albuterol 100mcg as needed instead of daily. This approach reduced the amount of steroids given, and may result in better adherence as well. (Level of evidence 1b.) The as-needed combination course resulted in: (a) fewer exacerbations than the albuterol only group (0.74 per year vs 1.63 per year; P<.001); (b) number of exacerbations similar to that of the group taking beclomethasone daily and as-needed albuterol; (c) a total steroid dose 60mg less than that of the daily-steroid group (18mg vs 78mg); (d) a percentage of symptom-free days similar to that of the group taking medications daily. (Original article reviewed: N Engl J Med 2007; 356:2040-2052.)

28-089 Improving asthma-related health outcomes among low-income, multiethnic, school-aged children: results of a demonstration project that combined continuous quality improvement and community health worker strategies.

Fox P, Porter PG, Lob SH, et al. Pediatrics. October 2007. Vol.120. No.4. p.e902-11.
Reviewed by Dr Jocelyn Tracey
Review: The intervention implemented in seven clinics was a team-based CQI process to develop clinic-specific systems changes to the care process and support from a CHW to provide linkages between clinical providers, the home, school, etc. Both

process and outcome measures were used to evaluate this intervention.
Comment: Useful for PHOs designing clinical programmes.

Cardiovascular System

28-090 Current management of acute coronary syndromes in Australia: observations from the acute coronary syndromes prospective audit

Chew DP, Amerena J, Coverdale S, et al. Intern Med J. November 2007. Vol.37. No.11. p.741-8.
Reviewed by Dr Helen Moriarty
Review: A multicentre registry was set up to prospectively describe current care of acute coronary syndromes. The paper reports on 3402 patients in this registry. Quantification of the risk profile (STEMI vs low and high risk non-STEMI) was not always evidence-based, e.g. compared to guidelines reperfusion rates for STEMI were sub-optimal. However, the various clinical practice differences were not reflected in adverse patient outcomes. The authors acknowledge that this study does reflect that point of care clinical decision-making might take into account recommendations in protocols but may not necessarily follow these.
Comment: Interesting that the variable adherence to invasive techniques did not impact on patient outcomes, and this raises questions about using invasive investigations and treatments as frequently as present fashion dictates.

28-091 Atrial fibrillation in Australian general practice

Fahridin S, Charles J, Miller G. Aust Fam Physician. July 2007. Vol.36. No.7. p.490-1.
Reviewed by Dr Mary Tucker
Review: This article provides an analysis of encounters, over a two year period, in which the most frequently treated arrhythmia, Atrial Fibrillation, was managed in Australian general practice. The majority of encounters were in patients over 65 years of age – frequency increasing with age. Hypertension was the commonest co-morbidity, followed by diabetes and hyperlipidaemia. Coagulation studies, monitoring warfarin therapy, resulted in a disproportionately high rate for pathology testing in this group of patients.
Comment: Setting the scene for the articles in this issue of *Australian Family Physician* on the theme of cardiac arrhythmias (see 28-091 to 28-097).

28-092 Emergency management of acute cardiac arrhythmias

Grantham HJ. Aust Fam Physician. July 2007. Vol.36. No.7. p.492-7.
Reviewed by Dr Mary Tucker
Review: Arrhythmias requiring acute intervention and appropriate therapeutic options for their management are reviewed in this article. Acute intervention is not required for atrial fibrillation, unless of very recent origin, and for other arrhythmias that provide adequate perfusion. Level of consciousness is a key marker of cerebral perfusion and ischaemic chest pain of cardiac perfusion. Blood pressure measurement is a useful adjunct to assessment. Bradycardias: conscious patients with impaired peripheral perfusion are best managed acutely with increased oxygen and by optimising preload. Other measures include Atropine (>1mg) for sinus bradycardia and sympathomimetic drugs or internal or external pacing for other forms of bradycardia. Tachycardias: Supraventricular tachycardia (SVT) is not usually life threatening and is managed with the valsalva manoeuvre initially (or carotid sinus massage in those <50 years of age.) Unconscious patients with wide complex tachycardias and those who have arrested should be treated with a standard cardiac arrest approach: establishing effective resuscitation and early defibrillation. Conscious patients with ventricular tachycardia (VT) can be treated either chemically (amiodarone 300mg IV – drug of choice – or lignocaine 100mg IV) or with synchronised cardioversion.
Comment: The initial response to management for patients that are perfusing should be oxygen – 'a wonderful antiarrhythmic that does not decrease myocardial contractility' – optimising preload and patience. For rhythms that are not perfusing a standard cardiac arrest procedure, as summarised in this article, should be followed.

28-093 Pharmacologic management of tachycardia

Kistler PM, Obeyesekere MN. Aust Fam Physician. July 2007. Vol.36. No.7. p.500-5.
Reviewed by Dr Mary Tucker
Review: In this article an overview of the underlying mechanisms of atrial arrhythmias and their management (excluding atrial fibrillation which is covered elsewhere – see 28-091) and of the management of ventricular tachycardia and ectopics is presented. Acute and long-term management is

discussed and problems that would benefit from specialist assessment are identified. While the focus is on the relative benefits and possible adverse effects of pharmacotherapy, areas in which non-pharmacological measures such as catheter ablation, DC cardioversion and implantable cardiac defibrillators may be the treatment of choice are highlighted.
Comment: It is important to remember that pharmacological management should also address any underlying cardiac disease process. *The associated podcast discussed the importance of reassurance in sinus tachycardia, clarifies the use of Adenosine (as a therapeutic and diagnostic tool in SVT – reserved for the Emergency Department with cardiac monitoring), discusses the value of 'pill in the pocket' therapy for infrequent episodes of SVT and highlights the value of catheter ablation for frequent or severe episodes. *(http://www.racgp.org.au/AM/Template.cfm?Section=AFP_Podcasts&Template=/CM/ContentDisplay.cfm&ContentID=18986)

28–094 Management of atrial fibrillation

Kistler PM, Habersberger J. Aust Fam Physician. July 2007. Vol.36. No.7. p.506-11.
Reviewed by Dr Mary Tucker
Review: Much of the morbidity and mortality associated with AF is the result of thromboembolism. Thromboembolic risk assessment should be performed on all patients presenting with both paroxysmal and chronic Atrial Fibrillation (AF). The benefit of a 70% reduction in stroke risk produced by anticoagulation with Warfarin with a target INR of 2.0–3.0, compared with a 20% risk reduction produced by Aspirin, at a dose of 325mg, is well established, however risks associated with haemorrhage on Warfarin therapy (0.5–1.5% pa) outweigh the benefits in some patient groups. These groups are identified. The importance of rate control in relief of symptoms and prevention of complications is emphasized and the relative merits of pharmacological options are discussed. Cases in which rhythm control, using pharmacological therapy or direct current reversion, may be appropriate are discussed and the role of AV nodal ablation procedures in younger patients is explored.
Comment: The importance of the diagnosis and appropriate management of this common problem, which affects 5% of the Australian population aged >65 years and is associated with a significant increase in morbidity and mortality, is explored in this very relevant review. *The associated podcast expands on thromboembolic risk, the nature of atrial stunning, the importance of rate control and choice of medication (beta blocker or calcium channel blocker) and place of rhythm control using medication (Flecainide or Sotalol) or catheter ablation. *(http://www.racgp.org.au/AM/Template.cfm?Section=AFP_Podcasts&Template=/CM/ContentDisplay.cfm &ContentID=18986)

28–095 Catheter ablation techniques in managing arrhythmias

Kistler PM. Aust Fam Physician. July 2007. Vol.36. No.7. p.512-7.
Reviewed by Dr Mary Tucker
Review: The mechanism responsible for an arrhythmia is determined, using electrophysiological studies, before catheter ablation (CA) using cryotherapy or radiofrequency ablation is performed and following CA to determine the success of the procedure. Supraventricular tachycardia and atrial flutter can be cured with catheter ablation in 90–95% of cases, with low complication rates, targeting the re-entrant circuit or abnormal atrial focus. The major complication is damage to the AV node which requires pacemaker implant in <1% of cases. Catheter ablation, targeting triggers in the pulmonary veins, has a 70–80% success rate for patients, suffering from paroxysmal atrial fibrillation (AF), with structurally normal hearts who are not controlled on medical therapy and should be considered before long-term treatment with amiodarone is initiated. Ventricular tachycardia (VT) is uncommon in structurally normal hearts, but, for these patients, CA has a significant role. For patients with ventricular tachycardia postmyocardial infarction, CA is an effective adjunct to an implantable cardioverter defibrillator.
Comment: Pharmacological management of arrythmias is not curative and may be associated with significant morbidity. The role of catheter ablation in the treatment of arrhythmias is discussed in this article. *The associated podcast highlights the curative value of catheter ablation in SVT and the diagnostic value of cryotherapy. Risks of catheter ablation are discussed. The role of catheter ablation in AF and VT is explored. *(http://www.racgp.org.au/AM/Template.cfm?Section=AFP_Podcasts&Template=/CM/ContentDisplay.cfm &ContentID=18986)

28–096 Pacemaker therapies in cardiology

Toogood G. Aust Fam Physician. July 2007. Vol.36. No.7. p.518-24.
Reviewed by Dr Mary Tucker
Review: The evolution of pacemakers from single lead, fixed rate systems to multichamber, rate responsive systems is explored in this article. Increasingly sophisticated technology can treat not only bradycardias, but also tachycardias, patients at risk of sudden death (implantable defibrillators), and cardiac failure (cardiac resynchronisation devices). Pacemakers are most commonly indicated for the management of symptomatic bradycardia. International guidelines identify those for whom pacemaker implants will be of benefit. Regular follow-up is required. Advice for patients with pacemakers on the effects of electromagnetic fields is offered.
Comment: The impressive improvement in patients with refractory heart failure with the use of cardiac resynchronisation devices is an exciting advance. *The associated podcast explores the changing indications for pacemaker insertion and their impact on survival, the role of

cardiac resynchronisation devices in hear failure and information with regard to pacemaker insertion, monitoring and safety. *(http://www.racgp.org.au/AM/Template.cfm?Section=AFP_Podcasts&Template=/CM/ContentDisplay.cfm&ContentID=18986)

28-097 Integrative medicine and arrhythmias

Sali A, Vitetta L. Aust Fam Physician. July 2007. Vol.36. No.7. p.527-8.
Reviewed by Dr Mary Tucker

Review: Populations with a high fish intake are at the low incidence of coronary heart disease and death. Omega-3 fish oils have been shown to reduce sudden death from ventricular fibrillation, presumably by stabilising the electrical activity at the cell membrane. Fish consumption is associated with a reduced incidence of Atrial Fibrillation (AF) and the administration of omega-3 fatty acids prior to CABG reduced the incidence of AF in the postoperative period and was associated with a shorter hospital stay. A large population-based study (Cardiovascular Health Study) suggests that fish and omega-3 fatty acid consumption slow the heart rate, prolong the PR interval and reduce the likelihood of prolonged QT. A double-blind randomised placebo-controlled study of increased dietary potassium and magnesium intake in patients with frequent ventricular arrhythmias showed a significant reduction in the incidence of arrhythmia.

Comment: The role of nutrients in the prevention of arrhythmias is reviewed. Omega-3 fish oils and potassium and magnesium supplements have been shown to reduce the incidence of cardiac arrhythmias and could have a beneficial role to play in public health. While potassium levels are routinely monitored in patients on diuretic therapy, magnesium levels are not. Reduced magnesium levels may be of clinical significance in these patients.

28-098 Failure to diagnose: long QT syndrome

Bird S. Aust Fam Physician. July 2007. Vol.36. No.7. p.564-5.
Reviewed by Dr Mary Tucker

Review: This article examines a medical negligence claim involving an allegation of failure to perform and ECG leading to delay in diagnosis of long QT syndrome.

Comment: The importance of keeping in mind a possible cardiac cause for syncopal episodes in children and young people is highlighted, in particular when other medical problems co-exist, clouding the picture.

Dermatology

28-099 Which oral antifungal is best for toenail onychomycosis?

Hinojosa JR, Hitchcock K. J Fam Pract. July 2007. Vol.56. No.7. p.581-2.
Reviewed by Dr Bruce Adlam

Review: Terbinafine, 250mg taken daily for 12 weeks, is the best regimen for toenail onychomycosis due to better clinical and mycologic cure rates, tolerability, and cost effectiveness (SOR = A, meta-analyses).

28-100 Is low-dose doxycycline effective for rosacea?

J Fam Pract. July 2007. Vol.56. No.7. p.522.
Reviewed by Dr Bruce Adlam

Review: Compared with placebo, low-dose doxycycline (40mg controlled-release) was more effective for the treatment of acne rosacea. Side effects were minimal. However, only 22% of actively treated patients reported near or complete clearing of their lesions, and many patients may still request alternative treatment – including a higher dose of doxycycline. (Original article reviewed: J Am Acad Dermatol 2007; 56: 791-802.)

Comment: Eligible patients were otherwise healthy adults, 18 years of age or older, with moderate to severe rosacea (10 to 40 papules and pustules, telangiectasia, moderate to severe erythema, and two or fewer nodules).

28-101 Newborn skin: Part I. Common rashes

O'Connor NR, McLaughlin MR, Ham P. Am Fam Physician. 1 January 2008. Vol.77. No.1. p.47-52.
Reviewed by Dr Andrea Steinberg

Review: This is a useful detailed discussion of a significant source of parental concern in the new baby. Although most rashes are transient and benign, some require additional management other than reassurance. In the former group are erythema toxicum neonatorum, acne neonatorum, milia, miliaria, miliaria rubrum and transient neonatal pustular melanosis. Infants with unusual presentations or signs of systemic illness should be evaluated for Candida, viral, and bacterial infections. Seborrhoeic and atopic dermatitis may require active management.

Comment: Excellent photographs – could be used to reassure parents that their baby's skin condition is benign and self limiting. See 28-102 for Part II.

28-102 Newborn skin: Part II. Birthmarks

McLaughlin MR, O'Connor NR, Ham P. Am Fam Physician. 1 January 2008. Vol.77. No.1. p.56-60.
Reviewed by Dr Andrea Steinberg

Review: Birthmarks in newborns – pigmented, vascular and those resulting from abnormal development – are common sources of parental concern. The predicted size of lesions in adulthood is the most useful prognostic factor for development of malignancy in a congenital melanocytic nevus – lesions that are projected to grow to less than 1.5 cm in adulthood rarely progress to melanoma. Haemangiomas of infancy tend to involute and disappear after infancy unlike the nevus flammeus (port-wine stain) that may deepen in colour or develop varicosities, nodules, or granulomas. Pulsed dye laser therapy can be used to lighten lesions if appearance is a concern. The common nevus simplex ('stork bite' – caused by telangiectasias in the dermis) resolves spontaneously. Supernumerary nipples are common and benign; they are occasionally mistaken for congenital melanocytic nevi. High- and

intermediate-risk skin markers of spinal dysraphism (eg. dermal sinuses, tails, atypical dimples, multiple lesions of any type) require evaluation with magnetic resonance imaging or ultrasonography.
Comment: Useful table for determining risk of occult spinal dysraphism, the highest risk is with midline lumbosacral skin lesions (e.g., lipomas, dimples, dermal sinuses, tails, haemangiomas, hypertrichosis). See 28-101 for Part I.

28–103 Actinic keratoses

Chia A, Moreno G, Lim A, et al. Aust Fam Physician. July 2007. Vol.36. No.7. p.539-41.
Reviewed by Dr Mary Tucker
Review: Actinic keratoses (AK) are common in Caucasians who experience high levels of sun exposure. Although the rate of transformation to SCC is low, patients with AK require regular screening for the development of SCC as well as advice with regard to the use of sunscreen which not only prevent the development of new AK but speed the resolution of existing AK. The relative merits of cryotherapy (which targets keratinocytes and melanocytes while sparing most other tissues) and curettage, for individual lesions, are discussed. Field therapy treats large affected areas and targets expanded clones of dysplastic cells as well as visible AK. The relative merits of the agents used (5-fluorouracil, which interferes with DNA synthesis, Diclofenac in hyaluronic acid gel, which may act through COX-2 inhibition, Metevix, which acts as a preferential photosensitiser, and Imiquimod – an immune response modifier) are discussed.
Comment: Field and targeted therapies are increasingly combined for optimal management of AK lesions and have the benefit of treating subclinical lesions with a potentially superior cosmetic outcome.

Diabetes

28–104 The management of type 2 diabetes mellitus FOCUS on quality

Miser WF. Prim Care. March 2007. Vol.34. No.1. p.1-38.
Reviewed by Dr M Hewitt
Review: An overview of the morbidity and mortality associated with type 2 diabetes briefly, with evidence and recommendations for best management in primary care.
Comment: The key is diagnosis and careful, regular clinical review. Factors such as diet and psychosocial issues are as important in the long-term management as attention to microvascular complications.

28–105 Efficacy of cholesterol-lowering therapy in 18 686 people with diabetes in 14 randomised trials of statins: a meta-analysis

Cholesterol Treatment Trialists' (CTT) Collaborators. Lancet. 12-18 January 2008. Vol.371. No.9607. p.117-25.
Reviewed by Dr Tony Hanne
Review: The use of statins in diabetes has continued to be controversial but this review should do much to end the arguments. Statins reduced all mortality in diabetics by 9% and mortality from vascular causes by 21% per mmol/L reduction in LDL. This benefit was found regardless of the cholesterol level before treatment and regardless of whether there was already known vascular damage.
Comment: Adverse publicity about statins in the news media has made it harder to persuade diabetics of their value if they feel well. The challenge is to find ways to present this information to motivate patients. See 28-106 for commentary.

28–106 Statins for people with diabetes

Cheung BM. Lancet. 12-18 January 2008. Vol.371. No.9607. p.94-5.
Reviewed by Dr Tony Hanne
Review: See 28-105.

28–107 Type 2 diabetes mellitus: Guidelines for initiating insulin therapy

Yeap BB. Aust Fam Physician. July 2007. Vol.36. No.7. p.549-53.
Reviewed by Dr Mary Tucker
Review: The rationale for the introduction of insulin in poorly controlled type 2 diabetes is discussed and the therapeutic outcome is compared with that produced by the addition of a glitazone. A better outcome is achieved by the addition of insulin for patients with HbA1c >9.5% while addition of a glitazone is an alternative for those with HbA1c <9.5%. Indications for the introduction of insulin, and schedules for dosage adjustment are outlined.
Comment: The importance of patient education and of individualising therapy in the light of age and of lifestyle factors is emphasised.

Diagnosis

28–108 Liquid compared with conventional cervical cytology: a systematic review and meta-analysis

Arbyn M, Bergeron C, Klinkhamer P, et al. Obstet Gynecol. January 2008. Vol.111. No.1. p.167-77.
Reviewed by Dr Len Brake
Review: Here is a turn-up for the books as they say. This paper updates all available evidence including the landmark Italian trial of 45 000 women randomised to LB or conventional cytology. Colposcopy was performed on women with atypical smear results. With this powerful reliable trial included in the meta-analysis two questions were answered: First, more LB cytology smears were reported as abnormal. Secondly despite more abnormal tests being reported, the LB cytology smears did NOT lead to the detection of more CIN. That is – all the positive tests were FALSE positives.
Comment: In the USA apparently many labs have stopped reporting 'normal' smears in favor of the liquid based preservatives and 80% of the 'Ob-Gyns' use the LB smears. The author concludes, this review suggests that the saga of liquid based cytology be added to the list of cautionary tales in women's health. See editorial 28-109.

28-109 Evidence-based medicine versus liquid-based cytology

Sawaya GF. Obstet Gynecol. January 2008. Vol.111. No.1. p.2-3.
Reviewed by Dr Len Brake
Review: See 28-108.

28-110 Accuracy of ECG electrode placement by emergency department clinicians

McCann K, Holdgate A, Mahammad R, et al. Emerg Med Australas. October 2007. Vol.19. No.5. p.442-8.
Reviewed by Dr Patrick McHugh
Review: A prospective observational study that found among clinical 'experts', there is wide variation in the identification of the correct location for electrode placement, particularly in the lateral leads and in women.
Comment: This has significant implications when comparing ECG in which electrodes have been placed by different clinicians.

Ear, Nose and Throat

28-111 The evaluation and treatment of children with acute otitis media

Bhetwal N, McConaghy JR. Prim Care. March 2007. Vol.34. No.1. p.59-70.
Reviewed by Dr M Hewitt
Review: This is the most frequent diagnosis in pre-school children and the prevalence in the USA is 20% of ambulatory care visits. The volume and cost of prescribing antibiotics is critically analysed with best management being evidence based.

28-112 The march of malignant otitis externa

Plummer C, Litewka L. Intern Med J. October 2007. Vol.37. No.10. p.729-30.
Reviewed by Dr Helen Moriarty
Review: An interesting case report of missed otitis externa in a 77-year-old man, and accompanying radiography that reveals how malignant this disease can be.
Comment: A sobering reminder about a common disease entity.

Emergency Medicine

28-113 Propofol in emergency medicine: further evidence of safety

Green SM. Emerg Med Australas. October 2007. Vol.19. No.5. p.389-93.
Reviewed by Dr Patrick McHugh
Review: An editorial commenting on the increasing body of evidence supporting that when propofol is used in accordance with typical recommendations it is safe, highly effective and associated with extremely short recoveries in Emergency Department settings (see also 28-114 and 28-115).

28-114 Profiling adverse respiratory events and vomiting when using propofol for emergency department procedural sedation

Bell A, Treston G, McNabb C, et al. Emerg Med Australas. October 2007. Vol.19. No.5. p.405-10.
Reviewed by Dr Patrick McHugh
Review: A prospective, observational series of 400 patients undergoing procedural sedation with propofol in an Emergency Department setting that found no clinically evident adverse outcome. Patients did not need to be fasting, the occasional transient respiratory event occurred with these managed with basic airway interventions leading the investigators to conclude that propofol is a safe alternative for emergency physicians with which to provide emergent procedural sedation (see also 28-113 and 28-115).

28-115 Optimization of propofol dose shortens procedural sedation time, prevents resedation and removes the requirement for post-procedure physiologic monitoring

Bell A, Treston G, Cardwell R, et al. Emerg Med Australas. October 2007. Vol.19. No.5. p.411-7.
Reviewed by Dr Patrick McHugh
Review: A trial that found shorter sedation times are seen with lower doses of propofol; prolonged post-procedure monitoring is not required because the occurrence of spontaneous resedation associated with propofol use is a rare event with positive implications for patient flow and staff resource allocation in a busy ED (see also 28-113 and 28-114).

Endocrinology

28-116 Thyroid lumps and bumps

Brennan M, French J. Aust Fam Physician. July 2007. Vol.36. No.7. p.531-6.
Reviewed by Dr Mary Tucker
Review: Thyroid nodules are common – 7% adults have palpable nodules and 50% have nodules on USS. While the majority of thyroid nodules are benign, assessment and investigation aims to identify the 5% that are malignant and also to identify the systemic signs of hyper- or hypothyroidism and exclude co-existing hyperparathyroidism. Important features in the history and examination are highlighted in this review, a plan for appropriate assessment and investigation is outlined and management is discussed. Fine needle aspiration biopsy (FNAB) is considered to be the single most useful test in the assessment of a thyroid nodule in the absence of hyperthyroidism. The latter is better assessed using scintigraphy without the need for FNAB.
Comment: The diagnosis and management of thyroid nodules is discussed in this clinical practice review.

28–117 Skin and cushing syndrome

Phillips P, Weightman W. Aust Fam Physician. July 2007. Vol.36. No.7. p.545-7.
Reviewed by Dr Mary Tucker

Review: The symptoms, signs and pathophysiology of Cushing's syndrome and confirmatory diagnostic tests are graphically illustrated in this interesting case history.

Comment: Succinct presentation of a patient who felt 'like a traffic light stuck on red'.

Gastroenterology

28–118 Switching antibiotics mid-course improves H pylori cure rate

J Fam Pract. August 2007. Vol.56. No.8. p.608.
Reviewed by Dr Bruce Adlam

Review: Response to H pylori eradication has dropped to approximately 80% because of antibiotic resistance. A regimen of pantoprazole 40mg with amoxicillin 1g twice daily for the first five days, followed by pantoprazole 40mg, tinidazole 500mg, and clarithromycin 500mg, each administered twice daily for the remaining five days, was more effective than 10 days of continuous triple drug treatment. (Level of evidence = 1b; Individual randomised controlled trial (with narrow confidence interval).) (Original article reviewed: Ann Intern Med 2007; 146: 556-563.)

28–119 Dyspepsia

Conroy RT, Siddiqi B. Prim Care. March 2007. Vol.34. No.1. p.99-108.
Reviewed by Dr M Hewitt

Review: Although dyspepsia, as a term, covers a large number of possible conditions involving discomfort in the upper abdomen, the broad principles of treatment and best management rely on accurate diagnosis.

Comment: A recent review of dyspepsia treatment has been published by BPAC and feedback was invited. Reprints would be available on request.

Genetics

28–120 Diet advice from DNA?

Hercher L. Sci Am. December 2007. Vol.297. No.6. p.58-63.
Reviewed by Dr Ron Vautier

Review: There are now about a thousand genetic tests publicly available on the market, largely accessed through the Internet. Many of the companies selling these offer prognoses and nutritional advice purportedly based on the specific gene variants found, but in most cases the scientific rationale behind such advice is lacking.

Comment: While it appears reasonable to expect that someday DNA testing may provide useful specific advice for all patients, GPs should know that so far this is not true.

Gynaecology

28–121 What are the best treatments for herpes labialis?

Chon T, Nguyen L. J Fam Pract. July 2007. Vol.56. No.7. p.576-8.
Reviewed by Dr Bruce Adlam

Review: Evidence-based answer: There are three: Valacyclovir, 2g twice in one day taken during the prodromal stage of herpes labialis, reduces the episode duration and time to healing. Acyclovir, 400mg, taken five times a day for five days, decreases the pain duration and healing time to loss of crust. Topical penciclovir 1%, acyclovir 5%, or docosanol 10% also decrease the duration of pain and healing time (SOR = A, based on RCTs). The best prophylaxis for herpes labialis is oral valacyclovir 500mg daily; it reduces the frequency and severity of attacks (SOR = B, based on RCT). Sunscreen may be effective in sunlight-induced recurrence (SOR = B, based on two small crossover RCTs).

Comment: Clinical commentary includes a tip to let patients self-treat at the earliest signs.

28–122 Premenstrual syndrome

Kwan I, Onwude JL. Am Fam Physician. 1 January 2008. Vol.77. No.1. p.82-4.
Reviewed by Dr Andrea Steinberg

Review: This excellent evidence summary presents the efficacy of available treatments for PMS. Of the available drug treatments, luteal-phase spironolactone has been found to be beneficial and additional useful drugs that may be beneficial include NSAIDs and oral contraceptives. The adverse effects of Danazol, SSRIs and progesterones may limit their utility. Psychological interventions are discussed – there is no evidence that CBT is useful, and acupuncture, bright light therapy, chiropractic manipulation, exercise, reflexology and relaxation are of unknown effectiveness. Pyridoxine is likely to be beneficial as a dietary supplement, and calcium supplementation may improve symptoms. There is insufficient evidence to recommend the use of evening primrose oil and magnesium supplements.

Comment: Succinct summary of all available treatments.

Homeopathy

28–123 Benefits and risks of homeopathy

Goldacre B. Lancet. 17-23 November 2007. Vol.370. No.9600. p.1672-3.
Reviewed by Dr Tony Hanne

Review: This comment should be read alongside two other articles in the same issue, one of which reviews a toughening of attitude towards homoeopathy in the UK where it has long been tolerated by health authorities, and the other, which describes the major role of homoeopathy in India and the damage it causes (see 28-124 and 28-125). Meta-analyses of randomised controlled trials continue to show no benefit from homoeopathic treatments over placebo. The greatest concerns are around the marketing of these products by denigrating orthodox medicine in important conditions and discouraging immunisation against life-threatening illness

Comment: The effectiveness of homoeopathy lies in its placebo effect, but to obtain such an effect by unscientific propaganda undermines our attempts to have patients well

informed about their condition and intelligently involved in decision making which has been one of the great advances in medicine in the last 30 years.

28–124 Pressure grows against homeopathy in UK

Samarasekera U. Lancet. 17-23 November 2007. Vol.370. No.9600. p.1677-8.
Reviewed by Dr Tony Hanne
Review: See 28-123 and 28-125.

28–125 Homoeopathy booming in India

Prasad R. Lancet. 17-23 November 2007. Vol.370. No.9600. p.1679-80.
Reviewed by Dr Tony Hanne
Review: See 28-123 and 28-124.

Musculoskeletal System

28–126 Low back pain

McCamey K, Evans, P. Prim Care. March 2007. Vol.34. No.1. p.71-82.
Reviewed by Dr M Hewitt
Review: The aetiology, prevalence and recurrence of low back pain is discussed. Diagnosis and treatment are looked at from best management principles.
Comment: The New Zealand guidelines compiled with the assistance of ACC for the management of low back pain concur very closely with those of this article.

28–127 Osteoporosis: it's time to 'mind the gap'

Ebeling PR. Intern Med J. October 2007. Vol.37. No.10. p.672-3.
Reviewed by Dr Helen Moriarty
Review: A short editorial to remind GPs and hospital doctors alike that the first fracture is a time for action against osteoporosis, although technically already too late at that stage to prevent it. Another article in same journal (page 717-720, see 28-128) reports on a First Fracture Project where over-50s with a low trauma fracture are treated as at-risk patients.
Comment: As the second article points out, the costs of workup are significant but one hip fracture prevented offsets the cost of 54 other patients worked up.

28–128 First fracture project: addressing the osteoporosis care gap

Vaile J, Sullivan L, Bennett C, et al. Intern Med J. October 2007. Vol.37. No.10. p.717-20.
Reviewed by Dr Helen Moriarty
Review: See 28-127.

Neurology

28–129 Headache in primary care

McConaghy JR. Prim Care. March 2007. Vol.34. No.1. p.83-98.
Reviewed by Dr M Hewitt
Review: The author fully discusses the prevalence and aetiology of the three most common presentations of headache in primary care. Diagnosis and treatment are reviewed for migraine, tension headaches and chronic daily headaches.
Comment: Using the primary or secondary type of classification, then the above three discussed are by far the most prevalent.

Nutritional and Metabolic Diseases

28–130 Exercise and weight management

Matus CD, Klaege K. Prim Care. March 2007. Vol.34. No.1. p.109-16.
Reviewed by Dr M Hewitt
Review: Obesity in the United States is of major concern with all the accompanying morbidity and disease states. The authors give an overview for a multifactorial condition of complex origins and restate the obvious.
Comment: This is a huge problem (tee hee) both here and in the United States. 'Selfish genes' and evolutionary acquisitional energy status are thought to be major determining factors for weight control in indigenous populations.

28–131 Vitamin D deficiency in a multinational refugee population

Wishart HD, Reeve AM, Grant CC. Intern Med J. December 2007. Vol.37. No.12. p.792-7.
Reviewed by Dr Helen Moriarty
Review: The Mangere Refugee Service audited its routine practice of measuring vitamin D in the 700–800 refugees passing through the doors each year. Fifty-four per cent were low and 17% deficient, although only in the country for six weeks. Dark skin, living indoors, and covering skin when outside are all risk factors for low vitamin D, and dietary changes on migration are also a risk factor. Women of child-bearing age and those breastfeeding should especially be considered for screening as offspring are particularly at risk.
Comment: The paper recommends vitamin D supplementation of breastfed infants of refugee women. Vitamin D deficiency is also seen in NZ Maori children, obese children and Pacific and Maori adults, so GPs should keep this individual susceptibility in mind.

Obstetrics

28–132 Maternal smoking – a contributor to the obesity epidemic?

Chen H, Morris MJ. Obes Res Clin Prac. October2007. Vol.1. No.3. p.155-63.
Reviewed by Dr Anne-Thea McGill

Review: A review that outlines how small-for-gestational age babies can result from maternal smoking. Subsequent increased risks of (central) obesity, insulin resistance, diabetes and CVD (metabolic syndrome) have been seen in these offspring. Smoking has been shown to independently give rise to this same constellation of risks in mammals exposed to cigarette smoke and/or nicotine. Additionally, such exposure may alter peripheral and central mediators involved in the regulation of appetite and energy metabolism.
Comment: The links between maternal smoking and offspring obesity are well covered with a fairly clear review of the 'foetal origins' hypothesis. Preserved brain development at the expense of organ cell numbers (in most studies) and altered neural mediators are important features. Although maternal smokers have less healthy lifestyles (eat less fruit, vegetables and fibre but more sugars and fat, undertake less physical activity) foetal micronutrient and anti-oxidant malnutrition arising from maternal smoking could also have been discussed. However, these mothers-to-be are often the most powerless and disadvantaged in society. Non-judgemental support, free nicotine patches and nutritious food packages/vouchers could be more important for the next generation than we imagine. And all clinicians can advocate is to reduce poverty, displacement and societal causes of poor nutrition and smoking in pregnancy.

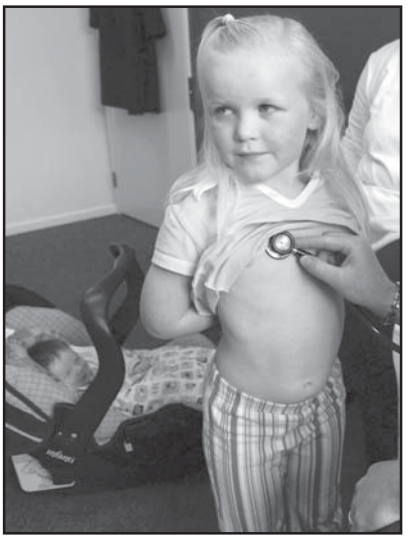
Paediatrics

28–133 How do toddler eating problems relate to their eating behavior, food preferences, and growth?

Wright CM, Parkinson KN, Shipton D, et al. Pediatrics. October 2007. Vol.120. No.4. p.e1069-75.
Reviewed by Dr Jocelyn Tracey
Review: This study gathered questionnaire data on 455 toddlers' eating habits and growth measurements up to 30 months of age.
Comment: Useful science to know when advising parents on toddlers with fussy eating habits.

28–134 Does cot death still exist?

Gornall J. BMJ. 9 February 2008. Vol.336. No.7639. p.302-4.
Reviewed by Dr Len Brake
Review: This is not a scientific 'paper' as such but rather a summary of the views of SIDS researchers. The term 'SIDS' was introduced in 1969 'partly for humanitarian reasons – being intended as a recognized category of natural death that carried no implication of blame for the bereaved parents'. New Zealand was to the forefront in the seventies and eighties with Drs Shirley Tonkin and Jack Sprott being two names that leap to attention for their input. Many causes were put forward and even today there are special mattresses with anti SIDS plastic wrappings and special ways to lay the baby to sleep, etc.
Comment: In summary, as Professor Risdon, a member of the SIDS foundation Board of trustees says, 'There will always be some babies who die unexpectedly and those parents need support. But in terms of justifying expensive research it is getting close to the point where it may be difficult.'



28–135 Progress on childhood obesity patchy in the USA

Devi, S. Lancet. 12-18 January 2008. Vol.371. No.9607. p.105-6.
Reviewed by Dr Tony Hanne
Review: Some 30% of children in the USA between six and 19 years of age are overweight and 15% are obese. The situation is substantially worse among Afro-Americans and Hispanics. The rate of childhood type 2 diabetes has doubled in recent years. It is predicted that this will be the first generation in a century in which children will have a shorter life-expectancy than their parents. There are a few bright spots in communities which have energetically tackled the problem by addressing many factors at once including the food industry, restaurants, advertising, exercise, places of recreation, education and family habits.
Comment: Small gains are being made where such approaches are being taken but it will be necessary to maintain momentum long-term to produce culture change. There is no one quick fix solution. New Zealand's problems are similar. As GPs we are best placed to lead a revolution

Pain Management

28–136 Fish, seal, and flaxseed oils lessened joint pain

J Fam Pract. August 2007. Vol.56. No.8. p.615.
Reviewed by Dr Bruce Adlam
Review: Yes. For patients with joint pain due to rheumatoid arthritis, inflammatory bowel disease, or dysmenorrhea, continuous therapy with fish oil or other sources of omega-3 fatty acids produced statistically significant decreases in pain. The onset of action is approximately three months. Even though the benefit may be small, the lack of signifi-

cant side effects and the beneficial effect on cardiovascular disease (see Circulation 2002; 106:2747-2757) make fish oil and other sources of omega-3 a useful option in patients with pain due to inflammation. (Level of evidence 1a: systematic reviews of randomised controlled trials). (Original article reviewed: Pain 2007; 129: 210-223.)

Comment: The benefit of omega-3s may be small, but their benefit with heart disease makes them a useful option for pain from inflammation.

28–137 Lignocaine is a better analgesic than either ethyl chloride or nitrous oxide for peripheral intravenous cannulation

Robinson PA, Carr S, Pearson S, et al. Emerg Med Australas. October 2007. Vol.19. No.5. p.427-32.

Reviewed by Dr Patrick McHugh

Review: Intradermal lignocaine was found to significantly reduce the pain of intravenous cannulation and was more effective than entonox, ethyl chloride or no analgesia. Cannulation success was not affected by the choice of analgesia.

Palliative Care

28–138 End-of-life care: guidelines for patient- centered communication

Ngo-Metzger Q, August KJ, Srinivasan M, et al. Am Fam Physician. 15 January 2008. Vol.77. No.2. p.167-74.

Reviewed by Dr Andrea Steinberg

Review: This is an excellent discussion of the different roles of the GP during different stages of terminal illness – breaking the bad news, communicating prognosis, discussing disease transitions, supporting the patient and caregivers, and coordinating care. The importance of patient-centred communication is stressed, and this article offers a systematic approach whereby GPs can discuss prognosis appropriately, offer realistic hope, provide therapeutic options, coordinate disease transitions, and relieve patient suffering. Customising discussion with regard to each patient's cultural values, understanding of the disease, wish to know more about their prognosis, etc. is essential for providing excellent care throughout a patient's illness, which can be highly gratifying for the GP and may lead to better patient outcomes.

Comment: A practical and most useful step-by-step approach to the 'human side' of terminal care.

28–139 Changes in symptoms and pain intensity of cancer patients after enrollment in palliative care at home

Dumitrescu L, van den Heuvel-Olaroiu M, van den Heuvel WJ. J pain Symptom Manage. November 2007. Vol.34. No.5. p.488-96.

Reviewed by Dr Peter Woolford

Review: This is joint Dutch and Romanian research. The Dutch have a well established and strong general practice similar to New Zealand. This paper analyses the changes in symptoms control following enrolment in a palliative home care programme. The details of this are not well described, but it appears that this is very similar to various home care programmes around NZ. The palliative care teams, doctors (GPs) and nurses delivered various interventions, the most common of which was counselling. It was clear that not only did the number of symptoms that patients suffered from decrease, but so did the intensity of those symptoms – particularly pain.

Comment: Caring for patients in their own home with appropriate palliative care support is a new concept in Romania and as such can be studied in quite a standardised way. This study reiterates the importance of home care in itself as a very powerful tool in the care of the dying, and the importance of the GP and nurse in delivering this care. Interestingly the greatest benefit was demonstrated for the urban poor – probably indicating that they had the most to gain in the first instance – and this is a finding that we need to be cognisant of in planning.

28–140 The role of general practitioners in continuity of care at the end of life: a qualitative study of terminally ill patients and their next of kin

Michiels E, Deschepper R, van der Kelen G, et al. Palliat Med. July 2007. Vol.21. No.5. p.409-15.

Reviewed by Dr Peter Woolford

Review: This elegant qualitative study from Belgium identifies (again) the pivotal role that GPs play in the care of the dying. Patients really wanted and appreciated the relational continuity – having an ongoing relationship with the same GP who keeps in contact with the patient and who feels responsible for the patient. They also identified informational continuity as very important, by which they meant using information on past events and personal circumstances to provide individualised care. The patients also identified some barriers to this care. Lack of time was talked about, as was the GP's lack of initiative – in other words they wanted the GPs to call spontaneously sometimes and to take control with suggesting management options. Financial restrictions were mentioned as was knowledge base.

Comment: There are no surprises in the fact that patients and families see their GP as pivotal in their care in the dying phase and value them immensely. However, the barriers identified were interesting and definitely transferable to NZ. The fact that patients and families want their GPs to be proactive about contacting them and suggesting management options for them reinforces the importance of this. Even from diagnosis, patients prefer to be told the diagnosis in their own homes, with family present, by their GP who they know and trust. From then, being proactive can just be a phone call after they have seen the oncologist or dropping by for a cup of tea on the way home to touch base.

28–141 Symptoms in patients receiving palliative care: a study on patient–physician encounters in general practice

Borgsteede SD, Deliens L, Beentjes B, et al. Palliat Med. July 2007. Vol.21. No.5. p.417-23.
Reviewed by Dr Peter Woolford

Review: A nationwide study (Belgium) looking at the prevalence of symptoms suffered by patients dying at home. The rationale was to look at the range of symptoms that GPs have to deal with in caring for the dying at home, (understanding that most people with an incurable illness want to be cared for at home) to give an indication of the range of skills and knowledge needed by GPs.

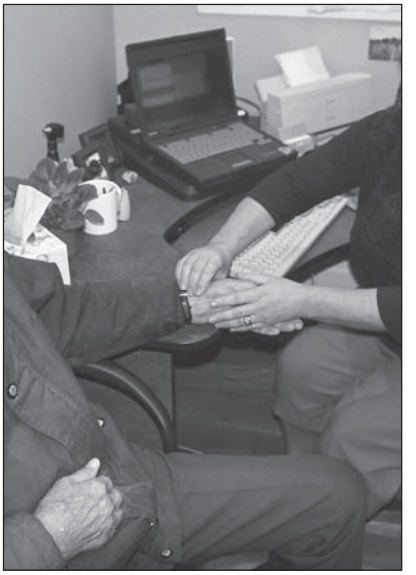
Comment: The authors comment that general practice palliative care is under threat as general practice becomes organised in different ways and that we must be very aware of this. GPs need to be supported (support for home visits, good quality education and access to palliative medicine specialists) to continue to deliver the care that patients and their families know is the best care.

Physician–Patient Relations

28–142 Catastrophe and caregiving: the failure of medicine as an art

Kleinman A. Lancet. 5-11 January 2008. Vol.371. No.9606. p.22-3.
Reviewed by Dr Tony Hanne

Review: The writer of this essay still remembers what seemed to him a glaring lack of sympathetic understanding by one of his medical professors some 40 years before. The technical part of diagnosis and treatment planning was appropriately done but the human suffering and the need for a doctor to respond to it with compassion and wisdom was ignored. He discusses the many ways of approaching this failure to include the art of medicine alongside the science, through psychology, art, music, ethics, and spiritual faith and asks how we can restore this dimension to modern medical training.



Comment: This article is well worth reading because it asks the questions that need to be faced if we are to combine 'pharmacological rationality with pastoral care'. Caring as a key part of general practice is more and more under threat as we are pressured to perform 'tick-box' medicine according to clinical targets.

Preventive Medicine and Screening

28–143 Cancer screening in the primary care setting: the role of the primary care physician in screening for breast, cervical, colorectal, lung, ovarian and prostate cancers

Miser WF. Prim Care. March 2007. Vol.34. No.1. p.137-67.
Reviewed by Dr M Hewitt

Review: As per the title.

Comment: Everything you always wanted to know about screening, but were afraid to ask!

Psychiatry and Psychology

28–144 Toddler–parent psychotherapy increases secure attachment between toddlers and mothers who have experienced major depressive disorder

Dawes S. Evid Based Ment Health. November 2007. Vol.10. No.4. p.123.
Reviewed by Dr Tannis Laidlaw

Review: This single blind randomised controlled trial recruited 130 mothers who had suffered a major depressive episode since their toddler was born approximately 20 months previously. Exclusion criteria eliminated confounders such as low socioeconomic status, low education and bipolar disorder. The intervention involved psychotherapy in the home aimed at correcting distorted perceptions of the child so the mother could alter her experiences of motherhood, but it took almost a year with an average of 45 sessions. An intervention manual and videotaped sessions minimised deviations from the agreed intervention. Results: Secure attachment and normalised attachment styles were developed by significantly more children in the treatment arm than the control. (Original article reviewed: J Consult Clin Psychol 2006; 74: 1006-16.)

Comment: Depression in mothers is associated with many undesirable consequences for their children. A major risk factor for children of depressed mothers is insecure attachment which is associated with conduct problems in childhood and youth, and mental health issues later in life. Presumably this was an expensive intervention by skilled psychologists but there should be many personal and social benefits in years to come for the individuals, the families and society. Commentator Dawe states 'One of the key messages for clinicians is what the authors refer to as the "malleability" of the attachment relationship in a child's early years.'

28–145 Parenting training improves problem behaviour in children at risk of conduct disorder

Melhuish EC. Evid Based Ment Health. November 2007. Vol.10. No.4. p.125.
Reviewed by Dr Tannis Laidlaw

Review: This single blind randomised controlled trial recruited three or four year old children who were showing signs of problem behaviour who were from socially disadvantaged backgrounds. The highly structured intervention had parents attend a 12-week positive parenting course run by supervised professional trainers. One hundred and four families were compared to 49 waitlist controls. Results: the children had significantly fewer conduct problems than the controls (follow-up one to two years) and the parents had significantly reduced stress and depressive symptoms, and increased competency ratings compared to the controls. (Original article reviewed: BMJ 2007, 334:678: 82.)

Comment: The UK government is funding parent support programmes in areas of social disadvantage. The results from this study were strong. Both children and parents benefited from the intervention. Commentator Melhish made the point that this programme which followed a set manual using professionals such as psychologists, social workers or health visitors is efficacious, unlike similar programmes run on an informal basis.

28–146 Review: psychotherapy plus antidepressant therapy increases response rate in people with panic disorder more than either treatment alone

Mitte K. Evid Based Ment Health. November 2006. Vol.9. No.4. p.98.
Reviewed by Dr Tannis Laidlaw

Review: This meta-analysis of RCTs (combined number of 1705) showed that a combination of psychotherapy plus antidepressants in the acute phase significantly improves treatment response in panic disorder compared with either just antidepressants or just psychotherapy. Long-term follow-up (six months to two years) showed that psychotherapy alone is as effective as the combination and more effective than antidepressant therapy alone. However, dropout rate was increased by the use of combination therapy in the acute phase. (Original article reviewed: Br J Psychiatry 2006; 188: 305-12.)

Comment: Mitte, the commentator on this paper said: 'So far, we do not know the efficacy of sequential order which is often used in clinical practice. In addition, there are not enough results concerning the impact of patients' characteristics on the beneficial effect of the single or the combination approach. So, how to decide? When considering the preferences of patients, many are unwilling to take active medication; others do not want to discontinue their current medication. The results of this review suggest that both preferences are acceptable (when ignoring the costs). However, it is important for the treatment of people with panic disorder to offer psychotherapy, and in particular CBT- alone or in combination. This might be the challenge for primary care.'

Public Health

28–147 Second thoughts about fluoride

Fagin D. Sci Am. January 2008. Vol.298. No.1. p.58-65.
Reviewed by Dr Ron Vautier

Review: The evidence remains strong that fluoride added to water supplies helps prevent tooth caries. (The mechanism involved is briefly discussed). It is also well established that too much ingestion of fluoride causes mottling of teeth. What remains debated amongst experts is what, if any, other adverse effects, such as weakened bones, bone cancer, a type of arthritis, and brain and thyroid disorders may result from excessive ingestion. Considering that there is intake from food and beverages, and toothpaste, the question of what is the optimum amount to have in the public water supply is very difficult to reliably answer.

Comment: I found this a balanced and informative consideration of the relevant epidemiology, well worth reading, at least by those practitioners who still retain an open mind in this long standing, emotionally charged, debate.

Reproduction

28–148 What is the best way to evaluate secondary infertility?

Davis III CH, Hall MN, Kaufmann L. J Fam Pract. July 2007. Vol.56. No.7. p.573-5.
Reviewed by Dr Bruce Adlam

Review: Evidence-based answer : The work-up for secondary infertility – the inability to conceive after one year of regular unprotected intercourse for a couple who have previously had a child – should include a history and physical exam for both patients, plus evaluation of ovulation, semen analysis, and imaging of the uterus and fallopian tubes (SOR = B, based on cohort studies). Check the male partner for varicoceles: they are the leading cause of male secondary infertility. For the female partner, a hysterosalpingogram is an effective first test in the initial evaluation of the uterine cavity and tubal patency (SOR=B, based on cohort studies). Laparoscopy is indicated where there is evidence or strong suspicion of endometriosis, adhesions, or significant tubal disease (SOR=B, cohort studies). Routine postcoital testing is unnecessary (SOR=A, randomised controlled trial and cohort studies).

Comment: These simple steps may reveal treatable causes.

Respiratory Diseases

28–149 Pseudo-asthma: when cough, wheezing, and dyspnea are not asthma

Weinberger M, Abu-Hasan M. Pediatrics. October 2007. Vol.120. No.4. p.855-64.
Reviewed by Dr Jocelyn Tracey

Review: This review article covers all the causes of persistent cough, wheeze

and shortness of breath in children very thoroughly: everything from habit cough syndrome to primary ciliary dyskinesia.
Comment: A useful reminder of the differential diagnosis and an update on rare conditions.

Respiratory System

28–150 Treating the immunocompetent patient who presents with an upper respiratory infection: pharyngitis, sinusitis and bronchitis

Mostov PD. Prim Care. March 2007. Vol.34. No.1. p.39-58.
Reviewed by Dr M Hewitt
Review: The author looks carefully at the reported rates of antibiotic prescribing for these presentations. The likelihood of a viral aetiology is high yet the prevalence of antibiotic prescribing is higher. An evidence-based approach for rational prescribing of antibiotics is discussed.
Comment: The approach will vary according to the prescribing practice profile and risk managment strategies for the prevention of serious complications.

28–151 Identifying severe community-acquired pneumonia in the emergency department: a simple clinical prediction tool

Buising KL, Thursky KA, Black JF, et al. Emerg Med Australas. October 2007. Vol.19. No.5. p.418-26.
Reviewed by Dr Patrick McHugh
Review: Data on the clinical features of patients presenting to hospital with community– acquired pneumonia were collected. Multivariate logistic regression was used to identify independent predictors of death and/or requirement for ventilatory or inotropic support then used to adjust an existing severity score and tested on a validation cohort. This information was used to propose that severe pneumonia could be predicted by two or more of: acute confusion; oxygen saturations < or =90%; respiratory rate > or =30/min; and either systolic BP <90 mmHg; or diastolic BP < or =60 mmHg.
Comment: A useful 'tool' especially with being simple and non-invasive although its accuracy was not perfect and should only be used in combination with clinical judgement.

Rheumatic Diseases

28–152 Dietary supplements for osteoarthritis

Gregory PJ, Sperry M, Wilson AF. Am Fam Physician. 15 January 2008. Vol.77. No.2. p.177-84.
Reviewed by Dr Andrea Steinberg
Review: This is a detailed review of dietary supplements commonly promoted to and used by patients with osteoarthritis. Glucosamine-containing supplements are among the most commonly used products for osteoarthritis. Although the evidence is not entirely consistent, most research suggests that glucosamine sulphate can improve symptoms of pain related to osteoarthritis, as well as slow disease progression in patients with osteoarthritis of the knee. Chondroitin sulphate also appears to reduce osteoarthritis symptoms and is often combined with glucosamine, but there is no reliable evidence that the combination is more effective than either agent alone. S- adenosylmethionine may reduce pain but high costs and product quality issues limit its use. Several other supplements are promoted for treating osteoarthritis, such as methylsulfonylmethane, Harpagophytum procumbens (devil's claw), Curcuma longa (turmeric), and Zingiber officinale (ginger), but there is insufficient reliable evidence regarding long-term safety or effectiveness.
Comment: Up to one-third of patients with OA have used dietary supplements for their pain – GPs should be aware of the evidence for the efficacy of these products.

28–153 Colchicine: what is its place in the management of acute gout?

Winzenberg T, Zochling J. Aust Fam Physician. July 2007. Vol.36. No.7. p.529-30.
Reviewed by Dr Mary Tucker
Review: A Cochrane Database Systematic Review provides the basis for this discussion of the place of Colchicine in the management of acute gout. While efficacy at a dose of 1mg orally initially followed by 0.5mg two hourly has been demonstrated, the high incidence of gastrointestinal side effects limits its use at those doses. Evidence for the use of lower doses is weak and is based on case reports.
Comment: Colchicine remains a therapeutic option for those for whom NSAIDs and oral or intra-articular steroids are contraindicated. Further research is needed to elucidate the role of lower doses of Colchicine in the management of acute gout.

Screening

28–154 How well do people recall risk factor test results? Accuracy and bias among cholesterol screening participants

Croyle RT, Loftus EF, Barger SD, et al. Health Psychol. May 2006. Vol.25. No.3. p.425-32.
Reviewed by Dr Tannis Laidlaw
Review: In a study of 495 participants who had all been given results of their cholesterol screening, only 38% could recall the level correctly, although their recall was somewhat better for the cardiovascular risk category in which the levels fell. Those with the most worrisome results were more likely to recall their level as lower than it actually was, illustrating a tendency to distort memory recall to be more favourable than reality. The results were unrelated to educational level, age, knowledge or a host of other variables.
Comment: Studies such as these confirm the importance of educating/counselling patients in the implications of test results that can reinforce information important to self-regulation of health. The use of broader risk categories is recom-

mended as they can be better remembered. This study also reminds clinicians that minimising personal bad news is a widespread aspect of human nature and needs to be taken into account.

Smoking

28–155 The most addictive drug, the most deadly substance: smoking cessation tactics for the busy clinician

Crane R. Prim Care. March 2007. Vol.34. No.1. p.117-35.
Reviewed by Dr M Hewitt

Review: Nicotine is both addictive and lethal with frequent long-term use. Most forms of 'quit' programmes fail. The author looks at what works best for most people and outlines the appropriate algorithms for success.
Comment: Overall, the figures are depressing; that is why most governments have turned to smoking cessation as a public health measure.

28–156 School smoking bans: do they help/do they harm?

Poulin CC. Drug Alcohol Rev. November 2007. Vol.26. No.6. p.615-24.
Reviewed by Dr Helen Moriarty

Review: A study based on a Canadian 2002 anonymous student survey. Outcome measures of smoking first cigarette in prior year and academic performance were compared to individual and school rules on smoking. Low SE status was an independent predictor of smoking students as expected, but interestingly the academic performance declined as smoking bans increased. Authors conclude that education outcomes and early school leaving should be monitored as possible impacts of school smoking ban policy.
Comment: School smoking bans have been widely implemented as a matter of principle and to achieve the ideal of a smoke-free environment, but, as this paper points out, there is no evidence that such policy prevents youth smoking.

Sports and Exercise Medicine

28–157 Physiological responses to rock climbing in young climbers

Morrison AB, Schoffl VR. Br J Sports Med. 1 December 2007. Vol.41. No.12. p.852-61.
Reviewed by Dr Chris Milne

Review: This review article considered 50 articles. It concludes with recommendations that children under age 16 years should not undertake intensive finger strength training, and that an elite adult climber's training regimen is inappropriate for an elite young climber.
Comment: As New Zealand has developed an increasing reputation for its outdoor adventure sports, it is important that we as doctors are aware of resources to monitor climbers. This excellent review article contains 116 references.

28–158 Contact events in rugby union and their propensity to cause injury

Fuller CW, Brooks JH, Cancea RJ, et al. Br J Sports Med. 1 December 2007. Vol.41. No.12. p.862-7.
Reviewed by Dr Chris Milne

Review: Rugby is a collision sport (to quote Tana Umaga – it's not tiddly winks). Not surprisingly, the tackle was the event causing the most injuries in this study of English professional players. In absolute terms, scrums and collisions were more risky events.
Comment: The data collected here present a similar picture to those collected by the NZRFU over the past decade. They are a good part of the root cause of the 'player welfare' phrase that is in such common use nowadays.

28–159 Preparticipation medical evaluation in professional sport in the UK: theory or practice?

Fuller CW, Ojelade EO, Taylor A. Br J Sports Med. 1 December 2007. Vol.41. No.12. p.890-6.
Reviewed by Dr Chris Milne

Review: This study examined preparticipation in screening amongst professional soccer, rugby union, rugby league and cricket clubs. Not surprisingly they found a variable style of evaluation, with no sports implementing best practice guidelines for players at all stages of their employment.
Comment: A sobering study, and it leaves the team doctor and club in a vulnerable position if a preventable injury or medical condition later affects a player.

28–160 Health benefits of tennis

Pluim BM, Staal JB, Marks BL, et al. Br J Sports Med. 1 November 2007. Vol.41. No.11. p.760-8.
Reviewed by Dr Chris Milne

Review: This review article examined 24 cohort or experimental studies. The authors found that regular tennis participation improved aerobic fitness, the lipid profile, bone health and produced a leaner body overall, there was improved cardiovascular morbidity and mortality.
Comment: Tennis truly is a game for life, and we should be encouraging our patients to continue playing it, despite the odd niggles that they may notice.

28–161 Muscle activation in coupled scapulohumeral motions in the high performance tennis serve

Kibler WB, Chandler TJ, Shapiro R, et al. Br J Sports Med. 1 November 2007. Vol.41. No.11. p.745-9.
Reviewed by Dr Chris Milne

Review: This biomechanical laboratory study examined the muscle firing pattern in 16 club level or higher tennis players, specifically looking at the tennis serve. It gave a clear picture of how coupled activations

establish the motions and positions of the arm in the tennis serve.
Comment: A great article for those specifically interested in tennis. It is important to remember that in tennis, as for other ball sports most of the kinetic energy imparted to the ball comes from the trunk and leg muscles.

28–162 Lateral epicondylitis in tennis: update on aetiology, biomechanics and treatment

De Smedt T, De Jong A, Van Leemput W, et al. Br J Sports Med. 1 November 2007. Vol.41. No.11. p.816-9.
Reviewed by Dr Chris Milne
Review: Tennis elbow is the most common injury associated with the sport. Studies have shown that novice tennis players tend to contact the ball later (with the wrist in slight flexion versus the slight extension seen in experienced players).
Comment: This is an excellent review article on this challenging problem, with 50 references. The article is of relevance to all lateral epicondylitis, not just that seen in tennis players.

Urology

28–163 What is the recommended workup for a man with a first UTI?

Breen DP, Wanserski GR. J Fam Pract. August 2007. Vol.56. No.8. p.657-8, 61.
Reviewed by Dr Bruce Adlam
Review: Evidence-based answer: Obtain a urine culture in all men with suspected urinary tract infection (UTI), to reliably diagnose an infection. For further evaluation, ultrasonography with abdominal radiography appears at least as accurate as an intravenous pyelogram (IVP) for detecting urinary tract abnormalities such as hydronephrosis, stones, or outlet obstruction.
Comment: Surprisingly this is based mostly on expert opinion as the authors report only scant literature, mostly of poor quality in their search. This is quite a good article which works pragmatically through the options and likely underlying issues.

Instructions for authors
New Zealand Family Physician publishes original papers on general practice and family medicine. We encourage editorials, case reports and invite readers to contribute to regular features.

Manuscripts
Manuscripts may be submitted in printed or electronic format, preferably the latter. If possible the article should be submitted on a 3.5 inch disk in Word format, or emailed to the address below as an attachment. Where possible use standard fonts (such as Arial or Times) and keep formatting to a minimum. Please send a covering letter signed by all authors stating that the manuscript is original, has been read and approved and that no part of it has been submitted for publication elsewhere. We ask that the manuscript is no longer than 2500 words and that the style conforms to that detailed in *'Uniform requirements for manuscripts submitted to biomedical journals'* (http://www.icmje.org/). Text should be double spaced and pages numbered. Display on a separate title page the title of the paper, author's name (first name, initial, surname) and degrees; up to three key words; a brief curriculum vitae (about two sentences) for each author, name and address of author to whom communications should be sent; acknowledgments of grants. Begin the text with an abstract of less than 150 words. Abbreviations should be kept to a minimum. Use SI units throughout. Photographs of authors are welcome and should ideally be provided in digital (jpg) format.

Ethical approval
Reports of research projects involving human subjects should include a statement indicating that the project has received ethical approval.

References
Refer to published material by inserting numbers serially in the text. List no more than 20 references on the last page in the order cited in the text. Abbreviate journal names in the style of Index Medicus, and refer to journal articles as follows: authors' surnames and initials, title of article, abbreviated name of journal, year, volume number, first and last page numbers. Refer to books as follows: authors, title of chapter, title of book, edition, publishing house and city, year, page numbers referred to. Check the accuracy of every reference.

Illustrations
Graphs, charts and line drawings should be clean, sharp, black on white and of high standard of reproduction. Photographs must be of a professional standard, must show clear detail, and should ideally be submitted in digital (jpg) format.

Competing interests
All authors will be asked to declare competing interests.

Publishing dates
New Zealand Family Physician is published six times annually, in February, April, June, August, October and December. Original papers are submitted to referees before being accepted for publication, and are published as soon as space permits.

Subscriptions
The journal is provided free to all members of the RNZCGP. Rates for others are $132 per year within New Zealand, $174 outside New Zealand (including postage). The Royal New Zealand College of General Practitioners, P O Box 10440, Wellington, New Zealand.

Editor
Dr Tony Townsend MGP (Otago) BSc FRNZCGP Dip Obst.

Editorial Board
Dr Bruce Arroll, Dr Andrew Divett, Professor Tony Dowell, Dr Pamela Hyde, Professor Marjan Kljakovic, Dr Lynette Murdoch, Mr Andrew Stenson, Dr Jocelyn Tracey, Dr Jo Scott-Jones.

Emeritus Editors
Professor Campbell Murdoch, Dr Ian St George, Dr Tessa Turnbull, Dr Rae West, Dr David Cook.

Management
Hugh Sutherland

Designer
Robyn Atwood

Advertising enquiries:
Colin Gestro ph: 09–489 8911, fax: 09–489 8941, email: colingestro@affinityads.com

All other correspondence to:
Cherylyn Borlase, Publications Coordinator
Royal New Zealand College of General Practitioners
P O Box 10-440, WELLINGTON
Email: nzfp@rnzcgp.org.nz

The *New Zealand Family Physician* is the official journal of the RNZCGP, however, views expressed are not necessarily those of the College, the editor, or the editorial board.

The Royal New Zealand College of General Practitioners