Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals reviewed in this issue
Aust Fam Physician*
Br J Sports Medicine*
Can Fam Physician*
J Fam Pract*
Lancet*
Med J Aust*
Physician & Sportsmed*
Postgrad Medicine*
Primary Care*
Sci American*
Venereology*
* Journals indexed in Index Medicus

Acupuncture

21-235 Acupuncture in General Practice.

Traum D. Aust Fam Physician. December 2000. Vol.29. No.11. p.1139-43.
Reviewed by Dr Barry Suckling

Review: Most GPs have accepted acupuncture in the treatment of a wide range of conditions. An attraction is that benefit can be obtained without drugs, and in chronic conditions the need for drugs can be reduced.

Comment: A good review of acupuncture and its place in the GPs armamentarium.

Alternative Medicine

21-236 Herbal medicine: an overview.

Pinn G. Aust Fam Physician. November 2000. Vol.29. No.11. p.1059-62.
Reviewed by Dr Barry Suckling

Review: This is the first of a series of 12 articles on herbal medicine for the general practitioner. They will not cover other alternative therapies. The intention is to clarify what has been proved effective and what is wishful thinking. (see 21-252)

21-237 What is complementary medicine?

Cohen M. Aust Fam Physician. December 2000. Vol.29. No.12. p.1125-8.
Reviewed by Dr Barry Suckling

Review: Marc Cohen is Director, Centre for Complementary Medicine, Faculty of Medicine, Monash University. The theme of the December issue of the Australian Family Physician is Complementary Medicine. In this article he defines complementary medicine and explores what distinguishes it from mainstream medicine. He sees 'conventional' and 'complementary' therapies, not as separate divisions, but more as existing across a spectrum, with multiple complementary dimensions. He sees optimal care as integrative.

21-238 Complementary medicine: Searching for the evidence.

Bensoussan A. Aust Fam Physician. December 2000. Vol.29. No.12. p.1129-33.
Reviewed by Dr Barry Suckling

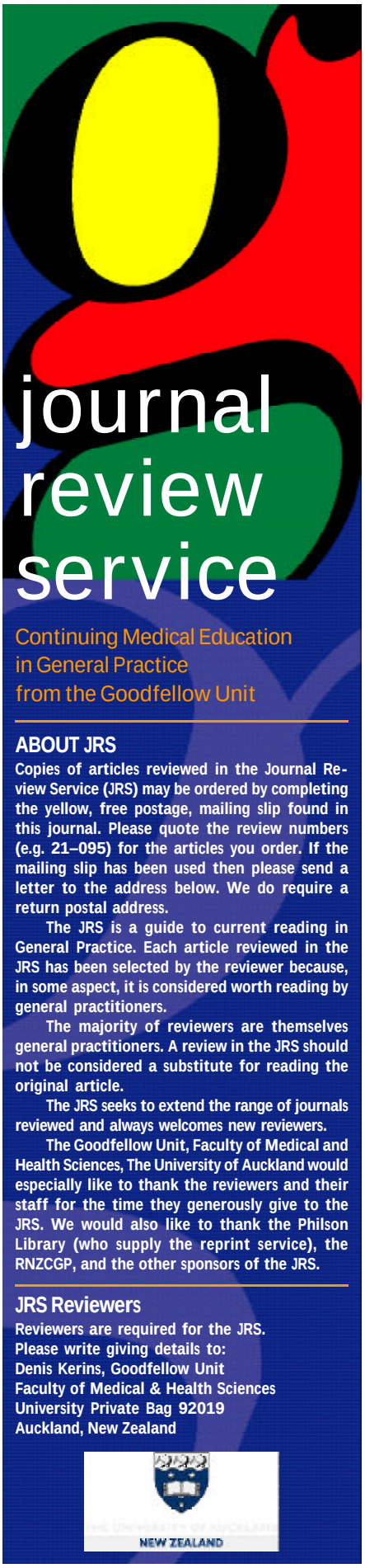
Review: Examines issues relevant to the evidence based assessment of complementary and alternative medicines. Though large numbers of randomised controlled trials form a growing body of research, the difficulty in performing trials means that evidence is often still lacking for many alternative interventions.

Comment: However, consumers are unlikely to rely on trials to be convinced of their effectiveness and relative safety.

21-239 Why meditation?

Manocha R. Aust Fam Physician. December 2000. Vol.29. No.12. p.1135-8.
Reviewed by Dr Barry Suckling

Review: Meditation is an effective form of stress reduction. It can improve quality of life and decrease health costs.



ABOUT JRS

Copies of articles reviewed in the Journal Review Service (JRS) may be ordered by completing the yellow, free postage, mailing slip found in this journal. Please quote the review numbers (e.g. 21–095) for the articles you order. If the mailing slip has been used then please send a letter to the address below. We do require a return postal address.

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

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

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

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

JRS Reviewers

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Most general practitioners now perceive meditation as an acceptable, even mainstream, health care strategy. It involves achieving a state of 'thoughtless awareness' in which the excessive stress-producing activity of the mind is neutralised without reducing alertness and effectiveness.
Comment: A good article with good references.

21-240 What is orthodox medicine?

Hassed C. Aust Fam Physician. December 2000. Vol.29. No.12. p.1192-3.
Reviewed by Dr Barry Suckling
Review: One definition might be 'what is commonly done by doctors' or 'what is accepted to be consistent with our current paradigms or scientific dogma'. Orthodoxy has far less to do with objectivity and science than we would generally like to think. The religion of yesteryear is often seen as dogmatic, but perhaps science, which is the religion of today for many, often demonstrates many of the same traits.
Comment: Another thoughtful article from Craig Hassed.

Asthma

21-241 Acute asthma: emergency management in the community.

Thomas P. Aust Fam Physician. February 2001. Vol.30. No.2. p.100-7.
Reviewed by Dr Barry Suckling
Review: As the title suggests.
Comment: A good review.

21-242 Epidemiology of asthma in children: who gets asthma and why?

Jalaudin BB, Marks GB. Aust Fam Physician. February 2001. Vol.30. No.2. p.109-13.
Reviewed by Dr Barry Suckling
Review: A good review of who gets asthma and why. Allergic or asthmatic parents, whose children have a high risk of developing asthma, should be advised to avoid smoking during pregnancy and avoid environmental tobacco smoke exposure after the child is born, to undertake house dust mite control, to breastfeed their babies for at least three months, and subsequently to provide their child with a balanced diet.

21-243 Management issues in adult asthma.

Hancock K. Aust Fam Physician. February 2001. Vol.30. No.2. p.114-20.
Reviewed by Dr Barry Suckling
Review: A good, sound review of standard asthma management in practice.

21-244 Moving towards organised care of chronic disease: The 3+ visit plan.

Fardy HJ. Aust Fam Physician. February 2001. Vol.30. No.2. p.121-5.
Reviewed by Dr Barry Suckling
Review: This article argues the case for the organised care of chronic disease (the 3+ visit plan). It uses asthma as the demonstration disease. A system of asthma care is described which is appropriate for General Practice. A series of visits ensure that all of the six steps of the Asthma Management Plan template (see Proactive Asthma Care 21-245) are covered.

21-245 Proactive asthma care: the benefits of behavioural change.

Tomlins R, Hope K. Aust Fam Physician. February 2001. Vol.30. No.2. p.127.
Reviewed by Dr Barry Suckling
Review: Health outcomes extend well beyond evidence based guidelines. Patients health beliefs have a significant effect. Risk asthma patients are those who deny the disease or their symptoms, or who distrust doctors and have no confidence in them. Their self-management often consists of tolerating symptoms and self medicating on relievers.
Comment: The 3+ visit plan (see 21-244) teaches intervention skills and behaviour change techniques. It allows recognition of such patients and assessment of their beliefs. Assertive intervention helps recruit them to a self-management programme - the 3+ visit plan. The national Asthma Campaign in Australia intends to introduce the plan through a national implementation programme.

Biochemistry

21-246 The cellular chamber of doom.

Goldberg AL, Elledge SJ, Harper JW. Sci Am. January 2001. Vol.284. No.1. p.56-61.
Reviewed by Dr Ron Vautier
Review: Proteasomes chop up proteins into amino acids (for recycling) and oligopeptides (for immune function). The proteins for destruction are identified by being tagged with ubiquitin molecules under the control of a special set of enzymes, which thus play a crucial role in controlling many cellular processes.
Comment: The elegance of today's biochemical knowledge is here elegantly illustrated. Furthermore, practical application in terms of new drugs is in the pipeline.

Cardiovascular System

21-247 Deep vein thrombosis.

Schubert H. Can Fam Physician Med Fam Can. January 2001. Vol.47. p.45-7.
Reviewed by Dr Mike Lyons
Review: Presents the case of a travelling businessman at the emergency department complaining of a sore calf after being on the squash court. Outlines risk factors, clinical features (poor correlation), diagnosis and treatment. Uses adaptation of Wells criteria to diagnose probability of DVT in table form.
Comment: Brief read. Too brief on treatment as the article forecasts GPs will treat more patients from day one when "if the patient can walk in to the emergency department, he or she can walk out". Store this article with a copy of *Management of deep vein thrombosis* by Beng Chong in the Australian Family Physician March 2001 and you will be prepared to deal with a condition where "less than half the patients eventually proven to have a DVT have symptoms or signs of it". Especially germane to Travel Clinics.

21-248 Physical activity and coronary heart disease in women: is 'no pain, no gain' passe?

Lee I-M, Rexrode KM, Cook NR, et al. JAMA. 21 March 2001. Vol.285. No.11. p.1447-54.

Reviewed by Dr Len Brake

Review: It is known that physically active women have lower coronary heart disease rates than non-active women. This study, using a cohort of over 39 000 women, looks at the intensity of the activity - in this case, walking - and also includes the women at high risk of CHD.

Comment: Generally, the time spent walking related to improved CHD outcomes rather than the rate of walking. (The Patient Page is included with this review).

21-249 Effects of atorvastatin on early recurrent ischemic events in acute coronary syndromes: The MIRACL study: a randomized controlled trial.

Schwartz GG, Olsson AG, Ezekowitz MD, et al. JAMA. 4 April 2001. Vol.285. No.13. p.1711-8.

Reviewed by Dr Len Brake

Review: The idea here was to check if early starting of atorvastatin post MI reduces death or non fatal ischaemic events. Randomly given either the statin or placebo, over 3 000 patients took part in the trial.

Comment: In summary, the death rate was the same for both groups but recurrent symptomatic ischaemic rate was reduced. A close call. See also the editorial 21-250.

21-250 Lipid-lowering therapy in acute coronary syndromes.

Sacks FM. JAMA. 4 April 2001. Vol.285. No.13. p.1758-60.

Reviewed by Dr Len Brake

Review: See 21-249.

21-251 Long-term MI outcomes at hospitals with or without on-site revascularization.

Alter DA, Naylor CD, Austin PC, et al. JAMA. 25 April 2001. Vol.285. No.15. p.2101-8.

Reviewed by Dr Len Brake

Review: Many studies have shown that patients who have their heart attack treated at hospitals with on site revascularisation and higher rates of invasive cardiac procedures do better than those treated at a hospital with fewer facilities. It is not known whether this difference is due to the invasive procedures or different patient or physician characteristics.

Comment: The study advises caution in attributing patient outcomes to any one factor. It is likely, it says, that the better mortality outcomes at the big hospitals is due to 'their teaching status'.

21-252 Herbs and cardiovascular disease: From past to present.

Pinn G. Aust Fam Physician. December 2000. Vol.29. No.12. p.1149-53.

Reviewed by Dr Barry Suckling

Review: This is the second article (see 21-236) in a series of 12 on herbal medicine. It reviews historical treatments for heart failure, and those drugs which have been developed from plants to treat cardiovascular related problems. It is likely that more will be discovered.

21-253 Is electron-beam computed tomography (EBCT) a reliable tool for predicting coronary outcomes in an asymptomatic population?

Stephens MB. J Fam Pract. August 2000. Vol.49. No.8. p.688.

Reviewed by Dr Bruce Adlam

Review: This meta-analysis suggests that EBCT is no better at predicting coronary outcomes than traditional risk factor modelling or the use of Framingham data, and that there is no evidence to support the routine uses of EBCT as a screening tool for coronary disease in an asymptomatic patient. (Original article: O'Malley PG, et al. Am J Cardiol 2000; 85:945-8)

Contraception and Family Planning

21-254 The combined oral contraceptive pill: a practical review of current options.

Riddoch G. Aust Fam Physician. November 2000. Vol.29. No.11. p.1039-44.

Reviewed by Dr Barry Suckling

Review: A good practical review. The minor differences with pill funding in New Zealand does not detract from the article.

21-255 Clinical breast and pelvic examination requirements for hormonal contraception: Current practice vs evidence.

Stewart FH, Harper CC, Ellertson CE, et al. JAMA. 2 May 2001. Vol.285. No.17. p.2232-9.

Reviewed by Dr Len Brake

Review: It's nice to have this information written down in black and white. Hormonal contraception can safely be provided based on careful review of medical history and BP measurement. Pelvic exams, cervical screening, swabs etc. are 'important in their own right' but do not aid the prescribing of hormonal contraception. Not only are these interventions unnecessary but they reinforce the belief that the pill is dangerous.

Diagnosis

21-256 Management of laboratory test results in family practice: an OKPRN study.

Mold JW, Cacy DS, Dalbir DK. J Fam Pract. August 200. Vol.49. No.8. p.709-15.

Reviewed by Dr Bruce Adlam

Review: This article describes a practice-based initiative for effective management of laboratory test results. Antibiotics are often prescribed for viral respiratory infections, the goal of this study was to determine the factors associated with antibiotic prescribing. The study found that patients who were older than 18, sick for more than 14 days and seen in urgent care clinics were more likely to receive antibiotics. Physical findings associated were rales, rhonchi, sinus tenderness and post-nasal drainage, purulent nasal discharge and a clear nasal discharge. Patient expectation of an antibiotic was not an independent predictor after some statistical gymnastics, in particular patients expect an antibiotic if they've had a similar illness in the past and it has improved with an antibiotic.

Comment: A commentary follows this article by PA James (see 21-257).

21-257 Managing patient information longitudinally: It's about time.

James PA. J Fam Pract. August 2000. Vol.49. No.8. p.716-7.

Reviewed by Dr Bruce Adlam

Review: See 21-256.

Emergency Medicine

21-258 Which patients with minor head injury do not need computed tomography?

Reynolds PL. J Fam Pract. October 2000. Vol.49. No.10. p.886.

Reviewed by Dr Bruce Adlam

Review: Head CT is not needed for minor head injury in patients with none of the seven findings listed. That is the following identified all patients with a positive CT: (1) Post-traumatic head pain, (2) Post-traumatic emesis, (3) Older than 60 years, (4) Drug or alcohol intoxication, (5) Deficits in short term memory, (6) Physical evidence of trauma above the clavicles, (7) Seizure. (Original article: Haydel MJ, et al. N Engl J Med 2000; 343: 100-5)

Endocrinology

21-259 Reducing cardiovascular risk in diabetes: which factors to modify first?

Spanheimer RG. Postgrad Med. April 2001. Vol.109. No.4. p.26-36.

Reviewed by Dr Chris Milne

Review: Complications of large vessel disease (e.g. stroke, myocardial infarction and heart failure) are the leading cause of death in diabetes. Hence, attention to cardiovascular risk factors with aggressive lowering of lipids and blood pressure, plus smoking cessation are the recommended strategies.

Comment: This article emphasises the fact that the focus has shifted from total concentration on blood glucose levels to a more inclusive strategy for prevention of long term complications.

Gastroenterology

21-260 Haemorrhoids: essentials of clinical management.

Hussain JN. Aust Fam Physician. January 2001. Vol.30. No.1. p.29-35.

Reviewed by Dr Barry Suckling

Review: Good practical guidelines on the diagnosis and treatment of haemorrhoids.

Geriatrics

21-261 Incidence of nursing home placement in a defined community.

Wang JJ, Mitchell P, Smith W, et al. Med J Aust. 19 March 2001. Vol.174. No.6. p.271-5.

Reviewed by Dr Ngaire Kerse

Review: A cohort of 3 654 persons, average age 50, were followed for five years as part of the Blue Mountains Eye Study (NSW). Predisposing factors: age, female gender, unmarried status, and living alone predicted nursing home (private hospital) admission in the next five years. Self-rated health, falls, use of community services, history of specific medical 'illness', and health risk behaviours, such as smoking, predicted nursing home admission. Five factors independently predicted nursing home admission: age, not owning your own home, self-rated health, walking disability, and smoking. Any alcohol consumption was protective. Thirty-five per cent of those over age 85 years were admitted to a nursing home within five years.

Comment: This study did not evaluate cognition, which has been shown to be an important predictor of nursing home admission. Remediable factors - smoking and walking disability are important for primary care doctors to concentrate on in avoiding nursing home admission for their patients.

Guidelines

21-262 Compliance with guidelines for continuity of care in therapeutics from hospital to community.

Mant A, Rotem WC, Kehoe L, et al. Med J Aust. 19 March 2001. Vol.174. No.6. p.277-80.

Reviewed by Dr Ngaire Kerse

Review: Compliance with guidelines for information transfer about medications for patients being discharged from hospital to the GP were evaluated by survey and a sample of 357 GPs. A minority (13%) of patients discharged had adequate communication from GP to hospital, and hospital to GP.

Comment: Watch out for adequate information about medications when admitting patients to hospital and receiving them back. Response rates in this survey were low but levels of appropriate practice were very low.

21-263 Randomised controlled trial to change the hospital management of unstable angina.

Heller RF, D'Este C, Lim LL-Y, et al. Med J Aust. 5 March 2001. Vol.174. No.5. p.217-21.

Reviewed by Dr Ngaire Kerse

Review: This study tested the implementation of a guideline for the management of unstable angina and randomised 48 hospitals to receive one educational session, run by an opinion leader for key clinicians, about National Heart Foundation guidelines for the management of unstable angina. The educational session included feedback from an audit of current practice. Charts were audited before and after the intervention to establish any change in practice including use of aspirin, heparin, beta-blockers, nitrates, coronary angioplasty, echocardiogram, and rehabilitation. There was an increase in use of beta-blockers in the control and intervention hospitals which was just short of statistical significance, and a definite decrease in use of calcium channel blockers when comparing intervention and control group hospitals.

Comment: The authors conclude that this intervention failed to influence practice. However, it was not an intensive or expensive intervention, and there were favourable changes in the use of at least two medications. Implementation of guidelines research is in its infancy. More effort can be put into implementation to fully and appropriately inform clinicians of the evidence base. (See 21-264 for editorial comment.)

21-264 Time to move beyond clinical practice guidelines?

Thompson PL. Med J Aust. 5 March 2001. Vol.174. No.5. p.211-2.

Reviewed by Dr Ngaire Kerse

Review: See 21-263.

Gynecology

21-265 Estrogen replacement therapy and ovarian cancer mortality in a large prospective study of US women.

Rodriguez C, Patel AV, Calle EE, et al. JAMA. 21 March 2001. Vol.285. No.11. p.1460-5.

Reviewed by Dr Len Brake

Review: Post-menopausal oestrogen use is associated with increased risk of endometrial and breast cancer. This large – over 211 000 women – study attempts to determine the effect of the oestrogens on ovarian cancer.

Comment: In summary, postmenopausal oestrogen use for over 10 years was associated with increased ovarian cancer. This higher mortality persisted for 29 years after cessation of the HRT.

21-266 Is there a simple and accurate algorithm that clinicians can use to more effectively select women for bone densitometry testing?

Gast P, Taylor T. J Fam Pract. August 2000. Vol.49. No.8. p.761-2.

Reviewed by Dr Bruce Adlam

Review: Yes, the most successful combination of variables have been designated the Ontario Risk Assessment Instrument (ORAI): (1) All women over 45 years and less than 60kg. (2) All women 55 to 64 years and less than 70kg and not taking oestrogen. (3) All women over the age of 65. (Original article: Cadarette SM, et al. CMAJ 2000; 162: 1289-94)

Comment: This study makes the comment that the best course of action once a diagnosis has been made is, however, less well understood (ie. cardiac effects, breast cancer and oestrogens, biphosphonates - expense and lack of long term efficacy and safety data). Lifestyle modifications (diet, exercise , smoking, and reducing the risk of falling) are cheap and effective in reducing fractures.

Homeopathy

21-267 Homeopathy: An overview.

Ballard R. Aust Fam Physician. December 2000. Vol.29. No.12. p.1145-8.

Reviewed by Dr Barry Suckling

Review: Reviews the principles underlying the practice of homeopathy and reviews some of the studies which attempt to understand its mechanism.

Comment: Its specific place in clinical practice is not yet determined. There is an accumulating body of evidence to show that homeopathy has a real effect.

Immunology and Allergy

21-268 Is it food allergy? Differentiating the causes of adverse reactions to food.

Guarderas JC. Postgrad Med. April 2001. Vol.109. No.4. p.125-34.

Reviewed by Dr Chris Milne

Review: Food allergy is uncommon, and the incidence decreases with age - as children grow older they often lose sensitivity to milk and eggs, but not to peanuts, fish and shellfish. Occasionally, toxins may be involved (e.g. botulinum or staphylococcal). Some children may have an aversion to a specific food for no other reason than dislike. Skin prick tests are valuable in excluding IgE mediated reactions (i.e. their negative predictive value is high).

Comment: Helpful article for demystifying a complex and often emotive topic.

Musculoskeletal System

21-269 How safe and effective are nonsteroidal anti-inflammatory drugs (NSAIDs) in the treatment of acute or chronic nonspecific low back pain (LBP)?

Griffin G. J Fam Pract. September 2000. Vol.49. No.9. p.780-1.

Reviewed by Dr Bruce Adlam

Comment: Safe. In acute back pain there was clear statistical evidence of slight global short-term improvement with NSAIDS without any statistically significant side effects. Not enough evidence to determine effectiveness in chronic back pain. They are slightly better than acetaminophen (similar to paracetamol). They are no better than muscle relaxants, narcotics, physiotherapy or spinal manipulation for acute LBP, however, they were somewhat better than bed rest. (Original article: Tulder MW van, et al. The Cochrane Library Oxford, England: Update Software; 2000)

21-270 Training in back care to improve outcome and patient satisfaction: Teaching old Docs new tricks.

Curtis P, Carey TS, Evans P, et al. J Fam Pract. September 2000. Vol.49. No.9. p.786-92.

Reviewed by Dr Bruce Adlam

Review: This is a prospective observational cohort study of 208 physicians. This article would have value to an organisation wanting to make an impact at a population level on low back pain. The pragmatic advice emerging is that the practitioner using a brief systematic evaluation and a hands on regional physical examination, and giving sound advice on pain management and prevention, and on an increasingly active exer-

cise programme, can modestly improve early patient functioning and satisfaction.
Comment: This article is followed by a commentary by Eric Henley who discusses Hadler's work on the risk factors in those who seek medical care for acute back pain and who develop chronic back pain (see 21-271). The strongest predictor is a history of back pain. Effects of psychosocial factors, the work environment and workers' compensation may have a role.

21-271 Understanding and treating low back pain in family practice.

Henley E. J Fam Pract. September 2000. Vol.49. No.9. p.793-5.
Reviewed by Dr Bruce Adlam
Review: See 21-270.

21-272 What is the optimal treatment for lateral ankle ligament ruptures?

Robins C, Seaton TL. J Fam Pract. October 2000. Vol.49. No.10. p.885.
Reviewed by Dr Bruce Adlam
Review: A meta-analysis of 27 RCTs and 3 300 patients. To improve long-term stability patients with lateral ligament ruptures should be managed aggressively; first by functional treatment or if this fails, surgery, followed by functional treatment. Functional intervention was described as bracing, wrapping, orthoses such as air casts, special shoes and cast immobilization for greater than three weeks. Anything less was considered minimal treatment. (Original article: Pijnenburg ACM, et al. J Bone Joint Surg 2000; 82-A: 761-71.)
Comment: The minimal treatments were associated with more frequent residual symptoms such as pain and giving way. Functional treatment was superior to six week cast treatments in pain and giving way. Ten per cent of patients undergoing operative treatment developed some surgical complication.

21-273 Site-specific techniques of joint injection.

Rifat SF, Moeller JL. Postgrad Med. March 2001. Vol.109. No.3. p.123-36.
Reviewed by Dr Chris Milne
Review: This article describes injection techniques for the shoulder, knee, elbow, wrist and foot. Twelve sites in all are discussed, with useful boxed diagrams of the sites involved and the recommended approach.
Comment: Useful article. The authors recommend a mixture of lignocaine and bupivacaine be added to triamcinolone. Most New Zealand experts would use a single local anaesthetic, usually lignocaine.

Neurology

21-274 Treating vertigo in the office: particle repositioning maneuver.

Frank C, Brown S. Can Fam Physician Med Fam Can. December 2000. Vol.46. p.2395-7.
Reviewed by Dr Mike Lyons
Review: Short article in 'Practice Tips' section on BPPV. Clearly describes Dix-Hallpike maneuver (Canadian spelling!) and Brandt/Daroff exercises.
Comment: Except for one crucial typo error, good article to file if you have not got the equivalent from the local neurology department or Murtagh's *Patient Education* book.

21-275 Does coffee protect against the development of Parkinson disease (PD)?

Hern T, Newton W, J Fam Pract. August 2000. Vol.49. No.8. p.685-6.
Reviewed by Dr Bruce Adlam
Review: In this prospective cohort study of 8 000 Japanese American men aged between 45 and 68, a dose response relationship was observed. Higher amounts of daily coffee intake were associated with lower risks of Parkinson's disease. However, this is a single study and a single study does not prove coffee is protective. (Original article: Gross GW, et al. JAMA 2000; 282: 2674-9)

21-276 Management of chronic tension-type headache with tricyclic antidepressant medication, stress management therapy, and their combination: A randomized controlled trial.

Holroyd KA, O'Donnell FJ, Stensland M, et al. JAMA. 2 May 2001. Vol.285. No.17. p.2208-15.
Reviewed by Dr Len Brake
Review: These daily headaches are a nightmare to manage in primary care. This RCT shows less startling responses but the antidepressants worked quicker with the combination therapy being the most successful. (Patient Page is attached)
Comment: The tricyclic doses in this trial were in the antidepressant range (75-100mg daily) not the low dose often used in 'pain control'.

Obstetrics

21-277 Is it always necessary to suture all lacerations after a vaginal delivery?

Triezenberg D. J Fam Pract. September 2000. Vol.49. No.9. p.781.
Reviewed by Dr Bruce Adlam
Review: No. Suturing minor non-bleeding postpartum lacerations (<2cm long and <2cm deep) does not improve healing rates or decrease discomfort. (Original article: Lundquist M, et al. Birth 2000; 27: 79-85.)

Occupational Health

21-278 Occupational and environmental medicine and primary care.

Frumkin H. Prim Care. December 2000. Vol.27. No.4. p.813-29.
Reviewed by Dr M Hewitt
Review: This is an introduction to the subject with a broad overview of how Primary Care is involved, and how occupational and environmental health issues commonly impact. Patient presentation and the approach used by the primary care physician is analysed and discussed.

21-279 Work-related upper extremity musculoskeletal disorders.

Mani L, Gerr F. Prim Care. December 2000. Vol.27. No.4. p.845-64.

Reviewed by Dr M Hewitt

Review: Wrist, elbow and shoulder disorders which commonly present are discussed. The context is within an analytical, diagnostic approach, involving a full understanding and explanation of the adverse work-related factors.

Comment: A good summary of ergonomic adverse exposures. Facilitates successful treatment in which these provoking factors are eliminated or modified.

21-280 Work-related low back pain.

Gerr F. Prim Care. December 2000. Vol.27. No.4. p.865-75.

Reviewed by Dr M Hewitt

Review: A description of a common presenting problem of workers, includes appropriate history and examination. Full account is taken of the provoking occupational risk factors during the assessment. Preventative strategies are discussed once a presumptive diagnosis has been made.

Comment: Not quite as useful or as comprehensive as the little ACC booklet *Guide to low back pain*.

21-281 Occupational skin diseases.

Lushniak BD. Prim Care. December 2000. Vol.27. No.4. p.895-915.

Reviewed by Dr M Hewitt

Review: As well as giving a good description of occupation related skin diseases such as contact dermatitis, infectious diseases and skin cancer, the author details statistics in respect of the industry of origin of the conditions. An epidemiological approach makes the diagnosis easier.

Comment: Useful reminder of the hazards of the work place and the consequences of unsafe practices in regards to handling materials.

21-282 Chemicals and gases.

Harrison RJ. Prim Care. December 2000. Vol.27. No.4. p.917-82.

Reviewed by Dr M Hewitt

Review: The author realises that a full and comprehensive analysis of all severe reactions to chemicals and gases is beyond the scope of this article. Instead he concentrates on the common ones that the primary care physician is likely to encounter - i.e. acids, alkalis, acrylomides, preservatives, vinyl chlorides, and common industrial gases.

Comment: Chemical warfare weapons not included!

21-283 Exposure to metals.

Hu H. Prim Care. December 2000. Vol.27. No.4. p.983-96.

Reviewed by Dr M Hewitt

Review: Examination and discussion of the threats of exposure to the common heavy metals - lead, cadmium, arsenic and mercury in the US work place and environment. Detection of toxic levels of exposure and methods of analysis are given, along with a range of values to distinguish normal from unsafe to toxic and harmful levels.

Comment: Brief mention of the toxic dental effect of mercury amalgams without much detail of reliable diagnostic criteria.

21-284 Upper respiratory problems.

Epling CA. Prim Care. December 2000. Vol.27. No.4. p.997-1008.

Reviewed by Dr M Hewitt

Review: The article focuses on occupational causes and atmospheric irritants of environmental or industrial origin as a cause of upper respiratory problems. The author advises careful history-taking and examination as the prime means of distinguishing the aetiology of the presenting complaint.

Comment: There is often a difficulty in distinguishing an infective aetiology as a primary cause of these problems from an occupational one.

21-285 Occupational respiratory diseases.

Balmes JR. Prim Care. December 2000. Vol.27. No.4. p.1009-37.

Reviewed by Dr M Hewitt

Review: The lung is the end of the line for a wide variety of noxious inhaled materials, such as gases and particles of occupational and environmental origin. The author looks at diagnostic and other investigative processes to determine the aetiology and outcome of disease causing states.

Comment: Pulmonary function testing is a sensitive, early indicator of disease. Particularly useful in the context of adverse industrial origins.

Orthopaedics

21-286 Bisphosphonates in the prevention and treatment of glucocorticoid-induced osteoporosis.

Blair MM, Carson DS, Barrington R. J Fam Pract. September 2000. Vol.49. No.9. p.839-48.

Reviewed by Dr Bruce Adlam

Review: This review included RCTs assessed for methodological quality by the Jadad criteria. Bisphosphonates generally increase bone density at the lumbar spine but data is less clear concerning changes in the femoral head. Little information exists about the ability of bisphosphonates to reduce fracture risk in patients with glucocorticoid-induced osteoporosis. Postmenopausal women received the most benefit.

Comment: The article contains recommendations for clinical practice. One being: all patients beginning high dose (>7.5mg/day) long term (>6 months) glucocorticoid therapy should be evaluated for prophylaxis against osteoporosis as the majority of bone loss occurs within the first six months.

Palliative Treatment

21-287 Window of opportunity for pain control in the terminally ill.

Ahmedzai SH. Lancet. 28 April 2001. Vol.357. No.9265. p.1304-5.

Reviewed by Dr Tony Hanne

Review: A thoughtful commentary on a report in the same issue by Stefan Weiss (see 21-288) on why so many

terminally ill patients in the USA choose to live with all or much of their pain rather than seek more effective relief from their physicians. He discusses the reasons why patients fear the treatment more than the pain and the possible failure this represents by doctors either to treat optimally or to educate effectively.
Comment: One of the striking things about the study being discussed was that poverty and belonging to an ethnic minority were much more likely to lead people to endure pain which could have been relieved. One would hope that in New Zealand we do a little better for our terminally ill patients - but do we?

21-288 Understanding the experience of pain in terminally ill patients.
Weiss SC, Emanuel LL, Fairclough DL, et al. Lancet. 28 April 2001. Vol.357. No.9265. p.1311-5.
Reviewed by Dr Tony Hanne
Review: See 21-287.

21-289 Getting the most from your local palliative care service.
Cairns W. Aust Fam Physician. November 2000. Vol.29. No.11. p.1018-21.
Reviewed by Dr Barry Suckling
Review: Outlines the role of palliative care services and the ways general practitioners can engage with them. No one individual can meet the needs of palliative care and the team approach can bring a wide variety of skills and experience.

21-290 Psychospiritual and existential distress.
Kissane DW. Aust Fam Physician. November 2000. Vol.29. No.11. p.1022-5.
Reviewed by Dr Barry Suckling
Review: Describes a framework for considering existential distress for use by the GP. The framework includes issues of death, anxiety, meaning of life, grief resulting from loss, isolation, loss of control and loss of dignity. The demoralisation syndrome and its treatment are discussed. Avoiding boundary violations, that can arise from a 'burnt out' clinician, is discussed.

21-291 Pain management in palliative care: reviewing the issues.
Virik K, Glare P. Aust Fam Physician. November 2000. Vol.29. No.11. p.1027-33.
Reviewed by Dr Barry Suckling
Review: This is the first of two articles (see 21-292) reviewing the management of cancer pain within the context of its multidimensional nature.
Comment: This first article discusses each component of the experience of pain, involving pharmacological and non-pharmacological approaches.

21-292 Pain management in palliative care: Morphine and the 'new' opioids in 2000.
Virik K, Glare P. Aust Fam Physician. December 2000. Vol.29. No.11. p.1167-71.
Reviewed by Dr Barry Suckling
Review: The second of two articles (see 21-291). Discusses the various formulations of opioids and the use of the "new " opioids to provide a practical framework for opioid use in General Practice.

Pharmacology

21-293 Herb-drug interaction guide.
Braun L. Aust Fam Physician. December 2000. Vol.29. No.11. p.1155-6.
Reviewed by Dr Barry Suckling
Review: This is the first in a series of charts which highlight and summarise interactions between herbs and drugs. The series of charts will be produced in its entirety throughout 2001 in the Australian Family Physician.
Comment: They will be very useful for reference or to photocopy for patient use.

Physician-Patient Relations

21-294 The impact of patient-centered care on outcomes.
Stewart M, Brown JB, Donner A, et al. J Fam Pract. September 2000. Vol.49. No.9. p.796-804.
Reviewed by Dr Bruce Adlam
Review: At the risk of exposing my bias this is the article of the month for me. Although it is a small study with lower level evidence (an observational cohort study), it raises some very interesting issues regarding the association between patient centred communication in primary care visits, and subsequent health and medical care utilisation. In a nutshell, patient centered communication was correlated with the patient's perception of finding common ground. In addition positive perceptions were associated with better recovery from the patient's discomfort and concern, better emotional health two months later, and fewer diagnostic test and referrals.
Comment: The paper is followed by a commentary on the Science of Patient Centered care by Ronald Epstein (see 21-295).

21-295 The science of patient-centered care.
Epstein RM. J Fam Pract. September 2000. Vol.49. No.9. p.805-7.
Reviewed by Dr Bruce Adlam
Review: See 21-294.

21-296 The clown doctors.
Spitzer P. Aust Fam Physician. January 2001. Vol.30. No.1. p.12-6.
Reviewed by Dr Barry Suckling
Review: In 1966, the Humour Foundation was established in Australia, drawing on inspiration from the work of Patch Adams. They use performance skills, empathy and sensitivity to support, divert, and help patients and staff cope with difficult situations. Laughing at ourselves is part of not taking ourselves too seriously.
Comment: At a time of crisis sometimes we lose the bigger picture of the rich tapestry that life offers even in the process of dying.

21-297 Happiness and humour: a medical perspective.
Cohen M. Aust Fam Physician. January 2001. Vol.30. No.1. p.17-9.
Reviewed by Dr Barry Suckling
Review: The medical profession's focus on dealing with negative mental states has led to the suggestion of classifying 'happiness' as a major affective disorder (pleasant type). Epidemiological data suggests that

happiness is related to personality factors such as high self esteem, feelings of personal control and extroversion, and is unrelated to the ownership of consumer goods.
Comment: Recapturing the optimistic enchantment with life that is a part of childhood may be a key to happiness and health. Pronoia - the positive counterpart of paranoia is the belief that the universe is plotting to make you happy.

21-298 Finding your funny bone: incorporating humour into medical practice.

Yates S. Aust Fam Physician. January 2001. Vol.30. No.1. p.22-4.
Reviewed by Dr Barry Suckling
Review: Many people confuse seriousness with professionalism. A sense of humour enables us to separate who we are from what we do. When you go looking for humour it will find you. Your work will get easier, your relationships will improve and you will be less stressed.

21-299 How humour keeps you well.

Hassed C. Aust Fam Physician. January 2001. Vol.30. No.1. p.25-8.
Reviewed by Dr Barry Suckling
Review: *Studying humour is like dissecting a frog - you may know a lot but you end up with a dead frog.* (Mark Twain) The benefit of humour on health has long been recognised, but measuring the benefit is difficult. Do we take ourselves too seriously?
Comment: Is making people laugh who don't want to an ethical question? Will we require informed consent before we let a joke loose? *The most revolutionary act you can commit in today's society is to be publicly happy* (Dr Patch Adams).

Physiology

21-300 Making sense of taste.

Smith DV, Margolskee RG. Sci Am. March 2001. Vol.284. No.3. p.26-33.
Reviewed by Dr Ron Vautier
Review: This article describes the anatomy of taste buds and taste cells, and recent findings about the ion channels, receptor molecules and intra-cellular second messengers that stimulate neurotransmitter release across to the taste nerves, wherein patterns of activity code taste information.
Comment: Interesting to learn that the long held view that the tongue has distinct areas for sweet, sour, salt and bitter is simply wrong.

Preventative Medicine and Screening

21-301 Cooking and oxygen: an explosive recipe.

Burns HL, Ralston D, Muller M, et al. Aust Fam Physician. February 2001. Vol.30. No.2. p.138-41.
Reviewed by Dr Barry Suckling
Review: Patients on home oxygen are advised not to smoke. However, many use their oxygen while cooking. Three cases are described where the nasal prongs ignited.
Comment: A useful home oxygen fact sheet for patients is described.

Psychiatry and Psychology

21-302 Diagnosing and managing delirium in the elderly.

Conn DK, Lieff S. Can Fam Physician Med Fam Can. January 2001. Vol.47. p.101-8.
Reviewed by Dr Mike Lyons
Review: Four tables outline DSM-IV diagnostic criteria, common causes, management and basic lab workup. Albert's seven areas of history enquiry are covered. Two case studies reinforce the theory.
Comment: Good reinforcement.

21-303 Effectiveness of St John's Wort in major depression: a randomized controlled trial.

Shelton RC, Keller MB, Gelenberg A, et al. JAMA. 18 April 2001. Vol.285. No.15. p.1978-86.
Reviewed by Dr Len Brake
Review: Two hundred adult outpatients were randomly assigned placebo or St John's wort. Outcomes using the inadequate but best available measures showed that the St John's wort is not effective in treating major depression.

21-304 Targeting quality improvement activities for depression: implications of using administrative data.

Valenstein M, Ritsema T, Green L, et al. J Fam Pract. August 2000. Vol.49. No.8. p.721-8.
Reviewed by Dr Bruce Adlam
Review: Findings for IPAs and PHO's? This is a North American study looking at Health Care Organisations targeting patients with depression. The investigators found that quality assurance programmes that use administrative data to identify primary care patients with depression will select a cohort with relatively severe, recurrent depressive disorders. Most of these patients will receive standard treatment without quality improvement interventions and will continue to be symptomatic. To be effective they may need to offer intensive alternatives such as disease management programmes, intensive monitoring of patient compliance or stepped care.

21-305 Training general practitioners to recognise and respond to psychological distress and suicidal ideation in young people.

Pfaff JJ, Acres JG, McKelvey RS. Med J Aust. 5 March 2001. Vol.174. No.5. p.222-6.
Reviewed by Dr Ngaire Kerse
Review: This before and after comparison study evaluated the impact of a one-day training programme on GP's self-reported management of young people with psychological presentations. Outcomes were established by comparing results of a pre- and six week post-workshop audit. Patients completed GHQ, CES-D, depression symptom inventory and the suicidality inventory in the waiting room and GPs completed a diagnosis, and psychological assessment management plan. Recognition of patients with psychological distress by

GPs increased significantly. Management plans did not change and no long-term outcomes were evaluated.
Comment: Interestingly more patients who chose not to participate were rated by GPs as distressed, which means the effect of this intervention in this study is probably an underestimate. Also interesting that management did not change even though more patients with psychological distress were identified. The before and after study design means that these differences may have been due to other factors operating on Tasmanian GP's at the time. The analysis was not adjusted for the effect of clustering inherent in the design and the follow up period was very short. I suspect that this program altered GPs perceptive abilities with respect to psychological health. The observation that it did not alter management is of concern.

Public Health

21-306 Drowning awareness: prevention and treatment.

Fenner P. Aust Fam Physician. November 2000. Vol.29. No.11. p.1045-9.
Reviewed by Dr Barry Suckling
Review: Drowning is the second most common cause of death by accident in Australia. One quarter are aged 0-4 years. Commonest sites are non-tidal lakes and lagoons, private swimming pools, ocean beaches, bath tubs and buckets. Up to 10% of bucket drownings are due to child abuse.
Comment: Despite prevention strategies, including pool fencing, drowning rates in young children have remained static. In older children drowning rates have declined dramatically.

Respiratory System

21-307 Are high-dose inhaled steroids effective for chronic obstructive pulmonary disease (COPD)?

Rosenbaum D, Merenstein D, McCormally T. J Fam Pract. September 2000. Vol.49. No.9. p.781-2.
Reviewed by Dr Bruce Adlam
Review: No. A randomised double blind trial of 751 patients. High dose inhaled corticosteroid use has a minimal impact in patients with COPD. It did not alter the rate of decline and did not markedly affect health status. The only clinical benefit seen in this trial was a decrease in the frequency of exacerbations requiring oral steroids and antibiotics. Another study by Toogood (J Allergy Clin Immunology 1998; 102:705-13) suggests that potent inhaled steroids decrease bone mineral density and given the small benefit demonstrated, inhaled steroids should be used infrequently in patients with COPD. (Original article: Burge PS, et al. BMJ 2000; 320: 1297-303.)

Sex and Sex Roles

21-308 Sex and the school leaver: a comparison of the sexual practice of university and technical college students.

Grunseit AC. Venereology. 2001. Vol.14. No.1. p.17-9.
Reviewed by Dr Helen Moriarty
Review: Comparative surveys of university 1st year students from Sydney and nationwide trade apprentices. A self-completed questionnaire asked about sexual experiences and HIV knowledge plus risk practices. The university students exhibited less risk behaviour and participated in those activities at older ages (on average).
Comment: The paper concludes that university-based surveys, used extensively in the past, may underestimate youth behaviours. However, in New Zealand, some trade apprenticeship training institutions have become universities, so the distinction will be less evident in future NZ surveys.

21-309 Heterosexual and homosexual anal intercourse: an international perspective.

Smith G. Venereology. 2001. Vol.14. No.1. p.28-37.
Reviewed by Dr Helen Moriarty
Review: A review of the social science and public health literature on anal intercourse. While it is a central activity in men who have sex with men, it is a common but often unquestioned activity, for heterosexuals.
Comment: An informative discussion of the practices which will enable the GP to discuss issues more freely with their patients.

21-310 Intracavernosal injection therapy: does it still have a role in erectile dysfunction?

Chew KK. Aust Fam Physician. January 2001. Vol.30. No.1. p.43-6.
Reviewed by Dr Barry Suckling
Review: For a decade intracavenosal injection was the only treatment available. Oral sildenafil (viagra) is now the first choice. Injection therapy is a useful alternative if the response to maximum doses of sildenafil is inadequate, or if there are contraindications to sildenafil.

Sexually Transmitted Diseases

21-311 Next year's model?

Bowden FJ. Venereology. 2001. Vol.14. No.1. p.5-6.
Reviewed by Dr Helen Moriarty
Review: See 21-312.

21-312 Mathematical modelling: what it can offer to sexual health.

Moriarty HJ. Venereology. 2001. Vol.14. No.1. p.7-13.
Reviewed by Dr Helen Moriarty
Review: A NZ-based mathematical model which was established to help justify changes in practices in the detection and treatment of genital Chlamydia. Demonstrates the process of mathematical models and the types of questions they can answer.
Comment: The NZ guideline for best practice in management of genital Chlamydia has not yet been implemented. (Note: The reviewer was in two minds whether to review this paper as she is also the author. The decision to include the review was mine - editor). See also the Editorial 21-311.

Sports and Sports Medicine

21-313 Influence of rugby injuries on players' subsequent health and lifestyle: beginning a long term follow up.

Lee AJ, Garraway WM, Hepburn W, et al. Br J Sports Med. February 2001. Vol.35. No.1. p.38-42.

Reviewed by Dr Chris Milne

Review: 1 169 male rugby players who had played in the 1993–94 season were followed up in 1998 to assess the consequences of any injuries they had suffered in that season. By 1998, 43% of the players had retired, with reasons for retirement including employment (25%), an injury sustained playing rugby (26%), and family (10%). Only 9% of ex-players reported significant negative effects to employment, family life and health from injuries sustained during the 1993-94 season.

Comment: This study has significant relevance for New Zealanders, and I suspect the figures would be similar here. As the authors state, this cohort will need to be followed up for at least 20 years to fully assess the long term sequelae of their injuries.

21-314 Hip and pelvis injuries in runners: careful evaluation and tailored management.

Browning KH. Physician and Sportsmedicine. January 2001. Vol.29. No.1. p.23-34.

Reviewed by Dr Rob Campbell

Review: This paper describes examination techniques for hip/pelvis injuries. It has a good clinical reasoning approach and some excellent differentiating clinical tips.

Comment: An excellent paper with useful examination and management suggestions. This describes 99% of hip and pelvis problems but not groin problems. A good paper for your 'library'.

21-315 Evaluation and treatment of ankle sprains: clinical recommendations for a positive outcome.

Hockenbury RT, Sammarco GJ. Physician and Sportsmedicine. February 2001. Vol.29. No.2. p.57-64.

Reviewed by Dr Rob Campbell

Review: A review of evaluation involving a discussion of stress X-rays is the first half of this paper. Management is then discussed. A useful grading system for acute sprains and an algorithm for chronic problems is included.

Comment: A useful review, especially if you are just sending patients away with a prescription of rest and NSAIDs.

Therapeutics

21-316 Andropause: Testosterone replacement therapy for aging men.

Bain J. Can Fam Physician Med Fam Can. January 2001. Vol.47. p.91-7.

Reviewed by Dr Mike Lyons

Review: Caveats to begin – studies are mostly less than 10 years old in this new field and the sole author had a conflicting interest of a past grant from Organon for an andropause study. Keeping these in mind, key points are: (1) Andropause is a complex of symptoms in ageing men associated with low testosterone levels. (2) Consider measuring bioavailable testosterone in men who present with decreased energy, lower sexual interest and performance, irritability and anxiety. (3) Symptoms improve with treatment. (4) Testosterone has thus far not been shown to increase cardiovascular disease or, apparently, the risk of prostate cancer.

Comment: Interesting - I may have to rethink my Viagra failures!

21-317 N of 1 trials: Practical tools for medication management.

Nikles CJ, Glasziou PP, Del Mar CB, et al. Aust Fam Physician. November 2000. Vol.29. No.11. p.1108-12.

Reviewed by Dr Barry Suckling

Review: In single patient (n of 1) trials, a patient acts as his or her own control, to compare the effectiveness of a drug with another drug, or placebo, by using blinding and multiple crossover. Only prescribing medications if an individual has been shown to be a responder can greatly benefit patients and GPs. The authors

have established the infrastructure to offer a single patient trial service to GPs in Australia.

Comment: This has the potential to revolutionise prescribing for certain chronic conditions.

Urology

21-318 Interstitial cystitis: etiology, diagnosis, and treatment.

Nickel JC. Can Fam Physician Med Fam Can. December 2000. Vol.46. p.2430-40.

Reviewed by Dr Mike Lyons

Review: Medline review of the subject from 1979 to 1999. Only six randomised or controlled clinical trials were identified. Treatment suggestions were based on these but also best available clinical data. Etiology still debated. Diagnosis more clearly defined. Empiric, palliative and therapeutically marginal treatment options outlined from diet manipulation, antispasmodics, Pentosan polysulfate, Hydroxyzine and tricyclics. Intravesical therapy with DMSO and heparin like products are outlined (as well as likely relapses). Canada has not shared the enthusiasm of overseas groups for intravesical vaccine of BCG!! Supravesical diversion with cystectomy is an absolute last resort.

Comment: No new riveting revelations about this frustrating condition. Long term treatment strategy is advised. However, reading the article may lessen the frustrations in future. "Two excellent sources of information for patients and physicians" are quoted - web sites.

21-319 Renal colic and recurrent urinary calculi: management and prevention.

Laerum E, Murtagh J. Aust Fam Physician. January 2001. Vol.30. No.1. p.36-41.

Reviewed by Dr Barry Suckling

Review: 60-80% of patients with calculi and who are untreated, will experience recurrence within five years. This paper outlines the causes of urinary calculi and management, and discusses ways to prevent recurrence.