Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed In this Issue

Am J Sports Med*
Ann Emerg Med*
Aust Fam Physician*
BMJ*
Br J Sports Med*
Can Fam Physician Med Fam*
Evidence-Based Medicine*
Homeopathy*
Intern Med J*
J Fam Pract*
J Med Screen*
JAMA*
N Engl J Med*
Postgrad Med*
Prim Care*
Safeguard*
*Journals indexed in Medline

Alcohol and Substance Abuse

22-250 Improved psychosocial function following low-intensity, 12-week outpatient alcohol rehabilitation programme: preliminary report.

Feeney GF, Connor JP, Young R McD, et al. Intern Med J. April 2002. Vol.32. No.4. p.197-8.

Reviewed by Dr Helen Moriarty

Review: A preliminary report but one which emphasises the importance of considering psychosocial functioning as an output for addiction programmes. Most focus on client retention or abstinence but self reported functioning is most important. Biological indices also improved.

Comment: These patients were on naltrexone 50mg/daily - a drug available in NZ but not subsidised, although funded by some health insurance polices, and also fundable through a disability allowance.

Alternative Medicine

22-251 Adverse effects associated with herbal medicine.

Pinn G. Aust Fam Physician. November 2001. Vol.30. No.11. p.1070-5.

Reviewed by Dr Barry Suckling

Review: This article reviews the published material and highlights areas of major concern. There is increasing awareness of potential hazardous side effects. Also herbs and drugs can interact like drugs and drugs do.

Comment: We need to be aware of what patients are taking. If we do not ask we do not know. A good article, with many references to recent articles.

Cardiovascular System

22-252 A comparison of warfarin and aspirin for the prevention of recurrent ischemic stroke.

Mohr JP, Thomspon JL, Lazar RM, et al. N Engl J Med. 15 November 2001. Vol.345. No.20. p.1444-51.

Reviewed by Dr Len Brake

Review: This is a large and indeed clever trial comparing aspirin with warfarin anticoagulation (INR target of 1.4 to 2.8) in over 2000 patients with non-embolic stroke. Patients were followed for two years comparing rates of recurrent strokes, death and bleeding complications. The authors conclude that there is no advantage using warfarin anticoagulation (with INR 1.4 to 2.8) over aspirin in preventing strokes. A previous trial using a higher INR had to be stopped early due to high rates of increased bleeding.

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

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

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

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

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THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

22-253 Fish and omega-3 fatty acid intake and risk of coronary heart disease in women.

Hu FB, Bronner L, Willett WC, et al. JAMA. 10 April 2002. Vol.287. No.14. p.1815-21.

Reviewed by Dr Len Brake

Review: Eating fish and long chain omega 3 fatty acids reduces the risk of coronary heart disease. This has been measured in men. This study confirms that in a cohort study of women aged 34 to 59 years there was a similar substantial lower risk of coronary events during 16 years of follow up.

22-254 Are new antihypertensive agents better than old antihypertensive agents in preventing cardiovascular complications?

Dickerson LM, Carek PJ. J Fam Pract. January 2002. Vol.51. No.1. p.9.

Reviewed by Dr Bruce Adlam

Review: This study confirms that blood pressure control reduces the risk of cardiovascular complications in patients with hypertension. As a group, newer antihypertensive agents are as effective as the older antihypertensive agents in the prevention of cardiovascular mortality, fatal and nonfatal stroke, and fatal and nonfatal MI. However, the ß-blockers and diuretics are more effective in preventing cardiovascular events than ACE inhibitors and calcium channel ß-blockers. (Original article: Lancet 2001; 358:1305-15.)

Comment: Considering that ß-blockers and diuretics are much less expensive than the newer antihypertensive agents, they should remain first line in the treatment of hypertension.

22-255 The treatment of adults with essential hypertension.

Dosh SA. J Fam Pract. January 2002. Vol.51. No.1. p.74-80.

Reviewed by Dr Bruce Adlam

Review: This article deals with the issues surrounding hypertension. In USA only 53% of hypertensive patients are being treated and only 24% have their hypertension under control. This article reviews the treatment of essential hypertension in adults and the prognosis of untreated hypertension. Covers risk stratification, alternative therapies, lifestyle modification, drug therapy, and prognosis.

22-256 10-minute consultation: Newly diagnosed hypertension.

A'Court C. BMJ. 8 June 2002. Vol.324. No.7350. p.1375.

Reviewed by Dr Len Brake

Review: Initiating treatment for, and maintaining treatment for hypertension has been bread-and-butter work for GPs for the past 40 years. This is a one page 'What issues should you consider' and 'what should you do' for an otherwise well 59-year-old man with three consecutive high diastolic readings. Appropriate references including websites.

Comment: Good reminders, succinctly put.

22-257 Carvedilol reduced mortality and morbidity caused by myocardial infarction in patients with left ventricular dysfunction.

Jagasia DH, Shivkumar K. Evidence-Based Medicine. January/February 2002. Vol.7. No.1. p.15.

Reviewed by Dr Bruce Arroll

Review: This article compares patients being given Carvedilol versus placebo in patients who had had a myocardial infarction within 3 to 21 days. Only 20 patients needed to be treated to prevent either a death or a non-fatal MI. (Original article reviewed: Lancet 2001 May 5; 357: 1385-90)

Comment: The commentator claimed it is not possible to tell if this is a class effect of beta-blockers or if Carvedilol is better than the others. Carvedilol is now available in New Zealand fully funded for patients with heart failure who are intolerant of other beta-blockers and have an ejection fraction less than 25%.

Communicable Diseases, Infections and Parasites

22-258 A clinical prediction model did well in diagnosing paediatric group A ß-haemolytic streptococcal pharyngitis.

Del Mar CB. Evidence-Based Medicine. January/February 2002. Vol.7. No.1. p.32.

Reviewed by Dr Bruce Arroll

Review: This article compares four variables: cervical lymphadenopathy, tonsillar swelling, coryza and scarletiniform rash against two swab results and a rapid antigen test. The results showed that a score > 4 was as good as a rapid antigen test. (Original article reviewed: Arch Pediatr Adolesc Med 2001 Jun; 155: 687-91).

Comment: The commentator claimed clinician guess was not as good as the scoring system. He also made the point that while it is useful in patients in whom rheumatic fever is a possible

risk, it is of less concern in patients with low risk of rheumatic fever.

Dermatology

22-259 What is the most effective treatment for tinea pedis (athlete's foot)?

Tsveti Markova. J Fam Pract. January 2002. Vol.51. No.1. p.21.
Reviewed by Dr Bruce Adlam
Review: Evidence-based answer - topical therapy is effective for tinea pedis. Topical terbinafine has a 70% cure rate, is available over the counter (OTC), and requires only one to two weeks of therapy. Two other OTC topicals, tolnaftate and miconazole, require two to four weeks to achieve slightly lower cure rates, but are considerably less expensive. (Grade of recommendation: A) The most effective but expensive treatment for tinea pedis is oral terbinafine 250 mg twice a day for two weeks (94% clinical cure rate) and is best reserved for patients with hyperkerototic soles, severe disease, topical therapy failure, chronic infection or immunosuppression. (Grade of recommendation: B)

22-260 Diagnosis in dermatology: tricks of the trade.

Marks R. Aust Fam Physician. November 2001. Vol.30. No.11. p.1028-32.
Reviewed by Dr Barry Suckling
Review: A good overview with good advise. For this and the other dermatology articles in this issue it would be best to obtain a copy of the journal itself. A black and white photocopy will be less helpful. Some of the hints are: (1) Stick to the big picture. Don't get lost in minutiae. (2) The history should allow you to categorise conditions into major groups. (3) The site and whether the lesion involves the epidermis, are key points. (4) Touch the skin. Get used to the feel of lesions.

22-261 Management of psoriasis.

Cowen P. Aust Fam Physician. November 2001. Vol.30. No.11. p.1033-7.
Reviewed by Dr Barry Suckling
Review: Sufferers often feel they are being under treated. Localised psoriasis can be controlled with topical measures. Generalised psoriasis requires stronger treatment. UV is the first step up. Cytotoxics/immunosuppressants and vitamin A analogues can be used if UV fails. Evolving new treatments are briefly mentioned.

22-262 Acne: myths and management issues.

Clearihan L. Aust Fam Physician. November 2001. Vol.30. No.11. p.1039-44.
Reviewed by Dr Barry Suckling
Review: The earlier acne is treated the more likely scarring will be minimised; so a proactive approach is important. P. acnes resistance to topical and systemic antibiotics is becoming a global problem. Isotretinoin is the only treatment that targets all the four pathological processes of acne. (see 22-263)
Comment: Dispelling the myths of acne is important.

22-263 How common is acne?

Clearihan L. Aust Fam Physician. November 2001. Vol.30. No.11. p.1045.
Reviewed by Dr Barry Suckling
Review: A simple sheet to photocopy for patient education. Simple and clearly written. (see 22-262)

22-264 Rashes in infants: pitfalls and masquerades.

Orchard D. Aust Fam Physician. November 2001. Vol.30. No.11. p.1047-51.
Reviewed by Dr Barry Suckling
Review: Common conditions such as pityrosporum folliculitis, neonatal acne, cradle cap, eczema and food allergy are discussed. The rarer conditions of zinc deficiency and neonatal lupus are also described because of their possible serious consequences.
Comment: A good review.

22-265 Childhood atopic eczema.

Barnetson RS, Rogers M. BMJ. 8 June 2002. Vol.324. No.7350. p.1376-9.
Reviewed by Dr Len Brake
Review: Ten per cent of children have eczema and this percentage is increasing. The reasons for this increase are postulated along with an update on management in this excellent clinical review. Psychological effects are discussed along with other complications. Medication from bath oils to tacrolimus are detailed.
Comment: Are exclusion diets helpful? Concludes with the reminder that we are dealing with control and not cure.

Diagnosis

22-266 Improving medical diagnoses by understanding how they are made.

Sutherland DC. Intern Med J. May/June 2002. Vol.32. No.5/6. p.277-80.
Reviewed by Dr Helen Moriarty
Review: A viewpoint paper which discusses some of the systemic problems inherent in medical decision-making.
Comment: In my view this paper does not go far enough. It talks superficially about some of the "Doctor" factors in diagnostic error but does not explore the 'Doctor/Patient interaction' factors and reasons why these may occur - nor how to make sure they do not occur!

Ear, Nose and Throat

22-267 Do parents and physicians differ in making decisions about acute otitis media?

Sorum PC, Shim J, Chasseigne G, et al. J Fam Pract. January 2002. Vol.51. No.1. p.51-7.
Reviewed by Dr Bruce Adlam
Review: Another small study that showed that US and French parents were very similar to physicians in their judgments and treatment choices regarding AOM. They appear to be able to adopt the physician's point of view and to be selective in the use of antibiotics
Comment: Très bon!

22-268 What is the best treatment for impacted cerumen?

Lopez R. J Fam Pract. February 2002. Vol.51. No.2. p.117.
Reviewed by Dr Bruce Adlam

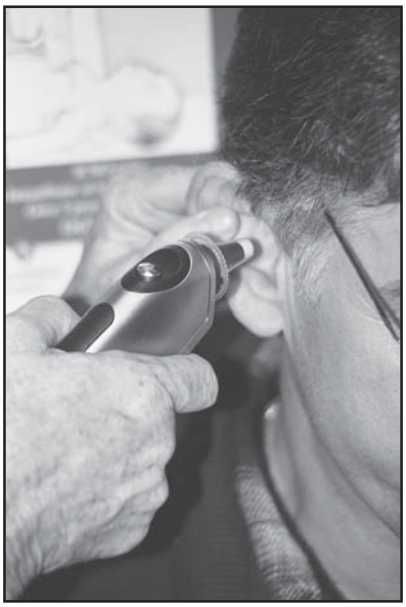

Photo: Michael Long

Review: The evidence based answer is - docusate sodium given 15 minutes before irrigation is most effective for facilitating cerumen removal during a single office visit. (Grade of recommendation: B) Treatment with 5% urea hydrogen peroxide in glycerol is most effective for facilitating cerumen removal between office visits, reducing the amount of irrigation needed. (Grade of recommendation: B)

Emergency Medicine

22-269 A randomized, controlled trial of panic disorder treatment initiation in an emergency department chest pain center.

Wulsin L, Liu T, Storrow A, et al. Ann Emerg Med. February 2002. Vol.39. No.2. p.139-43.
Reviewed by Dr Len Brake

Review: Chest pain is the most common physical symptom initiating medical consultation in a panic attack. Identification of these patients earlier in the piece saves time, and distress to both patient and family not to mention the doctor! This group have devised a screening strategy and have tested it in a randomised controlled trial.

Endocrinology

22-270 Oral agents for the treatment of type 2 diabetes mellitus: pharmacology, toxicity, and treatment.

Harrigan RA, Nathan MS, Beattie P. Ann Emerg Med. July 2001. Vol.38. No.1. p.68-78.
Reviewed by Dr Mike Slatter

Review: This review article examines currently available oral antidiabetic drugs (pharmacology, adverse effects, toxicities). It also describes treatment for sulfonylurea-induced hypoglycemia.

Comment: Discusses strategies for glycaemic control and causes for treatment failure in Type 2 Diabetes. Good coverage of Sulphonylureas and Biguanides. Important reading in keeping up to date in diabetes management.

Eye Diseases

22-271 Can high-dose supplementation with vitamins C and E, beta carotene, and zinc slow the progression of macular degeneration?

Gordon JE, Schooff M. J Fam Pract. February 2002. Vol.51. No.2. p.105.
Reviewed by Dr Bruce Adlam

Review: Answer= Possibly. Patients with moderate to advanced ARMD should consider taking an antioxidant/zinc supplement (NNT =11). Supplementation dosages of vitamin C (500mg), vitamin E (400IU), beta carotene (15mg), and zinc (80mg) for seven years. (Original article reviewed: Arch Ophthalmol 2001; 119: 1417-36).

Comment: Note: beta carotene has been linked to an increased risk of lung cancer in smokers.

Gastroenterology

22-272 Surgery relieved symptoms but decreased survival more than medical treatment in gastro-oesophageal reflux disease.

Richter JE. Evidence-Based Medicine. January/February 2002. Vol.7. No.1. p.26.
Reviewed by Dr Bruce Arroll

Review: This article compares 3 treatments. One being open Nissen fundoplication, continuous medical therapy such as two antacid tablets one and three hours after meals, ranitidine 150 mg BD and metoclopramide 10 mg qid prn and sucralfate 1 g in 10ml of warm water after meals or symptomatic treatment which consisted of any of the medical therapies given as needed. Follow up was after 11 years and 72% of the medical group were alive and 60% of the surgical group were alive. 62% of the surgical group versus 92% of the medical group were still on antireflux medication, 32% versus 64% in the proton pump inhibitor group, and 41% versus 65% in the H2 blocker group. (Original article reviewed: JAMA 2001 May 9; 285: 2331-8)

Comment: The commentator claimed that current laparoscopic Nissen is no better. He makes the point that although surgery is not a cure for all it does significantly reduce the need for antireflux medication. Patients need to understand the potential beneficial and adverse effects of antireflux surgery.

General

22-273 To review or not to review, that is the question.

McCroy P. Br J Sports Med. April 2002. Vol.36. No.2. p.80-1.
Reviewed by Dr Chris Milne

Review: The reviewer's job is an exacting one, for which few of us get any formal training. From the perspective of both the editor and author, a perfect review is rapid, impartial and constructive. Initially, one should decide if it is an appropriate paper to publish in the journal to which it has been submitted. Then, one should systematically analyse it for originality, content and readability. With the advent of computer

databases, a check on recent publications on the topic concerned should alert the reviewer to duplicate or redundant publications.
Comment: Very useful article about an important topic, about which very little has been published.

Gynaecology

22-274 Psychiatric issues related to infertility, reproductive technologies, and abortion.

Stotland NL. Prim Care. March 2002. Vol.29. No.1. p.13-26.
Reviewed by Dr M Hewitt
Review: The author describes the role of the primary care practitioner as a diagnostician for mild to moderate psychiatric disorders and then acting as an emotional conduit which can prevent and effectively treat them.
Comment: Effective care and treatment can be delivered with the correct diagnosis and strategy.

22-275 Menopause and perimenopause: The role of ovarian hormones in common neuroendocrine syndromes in primary care.

Vliet EL. Prim Care. March 2002. Vol.29. No.1. p.43-67.
Reviewed by Dr M Hewitt
Review: The fluctuations and decline of ovarian hormone function have a wide ranging effect on the health and well-being of women. These changes can be effectively treated with medication, subject to correct diagnosis. Testosterone is mentioned as an important treatment for loss of libido and low sex drive in women. Depression is seen as a consequence of menopausal changes (in these cases) and is treated as such. Hormone treatment appears to be as effective as anti-depressants.

22-276 Does this woman have an acute uncomplicated urinary tract infection?

Bent S, Nallamothu BK, Simel DL, et al. JAMA. 22/29 May 2002. Vol.287. No.20. p.2701-10.
Reviewed by Dr Len Brake
Review: How frequent is the scenario of a younger woman presenting with a UTI? Very frequent. Cystitis is a daily diagnosis for the family doctor. This study prods all academic corners and concludes that a good history is just as reliable an indicator of an UTI than the full examination, lab tests, etc.

22-277 Are progesterone or progestogens effective in managing premenstrual syndrome (PMS) symptoms?

Triezenberg DJ, Ang J. J Fam Pract. February 2002. Vol.51. No.2. p.109.
Reviewed by Dr Bruce Adlam
Review: Answer = No. Progesterone and progestogen therapy should no longer be prescribed for PMS. Evidence of effectiveness in reducing overall symptoms of PMS is better for other therapies. Similar systematic reviews show benefit from the use of selective serotonin-reuptake inhibitors (SSRIs) and vitamin B. Calcium therapy and chaste berry fruit extract have been reviewed in previous POEMs and have been found effective. (Original article reviewed: BMJ 2001; 323: 776-80).

Homeopathy

22-278 The starting point: pathography.

Swayne J. Homeopathy. January 2002. Vol.91. No.1. p.22-5.
Reviewed by Dr Marion Upsdell
Review: The reputation of Thomas Sydenham, the so-called 'father of modern clinical medicine', is said to have rested on his determination to observe and examine each individual patient with the open mind of a natural historian. Dr Swayne examines how homeopathy continues to study individual patients in a way best described as 'pathography'.
Comment: Most of the debate about homeopathy focuses on whether the medicines used have any biological effect. This article looks at the contribution it stands to make to a new understanding of disease processes.

22-279 Vitalism, complexity and the concept of spin.

Milgrom LR. Homeopathy. January 2002. Vol.91. No.1. p.26-31.
Reviewed by Dr Marion Upsdell
Review: In this article a chemist explores complexity and quantum theory, and proposes how new developments in the physical sciences may eventually impact on our current biomedical model.
Comment: While the connection of the so-called 'vital force', often described in alternative therapies, with molecular spin needs a lot more teasing out, this is nevertheless a very thought provoking article.

Musculoskeletal System

22-280 Does this patient have a torn meniscus or ligament of the knee? Value of the physical examination.

Solomon DH, Simel DL, Bates DW, et al. JAMA. 3 October 2001. Vol.286. No.13. p.1610-20.
Reviewed by Dr Len Brake
Review: Some ligament injuries and meniscus injuries need prompt repair and these patients do better with early diagnosis. The authors have used Medline searches and compared examination findings with arthroscopic findings. Results highlight the value of a good physical examination. The paper runs through the various tests for specific ligament damage.
Comment: A good reminder.

22-281 What is the initial approach to the treatment of shoulder pain?

Weismantel D, Abbott CM, Solomos NJ. J Fam Pract. January 2002. Vol.51. No.1. p.22.
Reviewed by Dr Bruce Adlam
Review: Evidence-based answer - there is some limited evidence supporting the use of NSAIDs in the initial treatment of shoulder pain. There is no evidence in support of most other therapies, including intra-articular or subacromial corticosteroid injection, intra-articular NSAID injection, oral corticosteroid treatment, physi-

otherapy, ultrasound, heat or ice therapy, laser treatment, electrotherapy, and iontophoresis. (Grade of recommendation: B) Manipulative therapy reported superiority over classic physiotherapy in the treatment of shoulder pain and if you are clever enough to distinguish synovial pain then an intra-articular corticosteroid injection was superior to both manipulative therapy and classic physiotherapy - although a recent Cochrane review concludes there is not enough evidence to confirm or refute this.

22-282 The effectiveness of magnet therapy for treatment of wrist pain attributed to carpal tunnel syndrome.

Carter R, Hall T, Aspy CB, et al. J Fam Pract. January 2002. Vol.51. No.1. p.38-40.
Reviewed by Dr Bruce Adlam

Review: Four recent randomised trials have provided conflicting results concerning the efficacy of magnets in relieving pain. Two double-blind randomised trials have found that magnets relieve pain in post-polio subjects and in patients with postoperative wounds. However, double-blind randomised studies of magnet therapy for treatment of low back pain and foot pain showed no benefit. This double-blind placebo-controlled randomised clinical trial, involving 30 patients with pain attributed to carpal tunnel syndrome, showed that despite significant pain reduction across the 45-minute period for both groups, t-test comparisons found no significant differences between the groups. The use of a magnet for reducing pain attributed to carpal tunnel syndrome was no more effective than use of the placebo device.
Comment: Thank goodness, I can delay my helping of humble pie.

22-283 Shoulder joint capsule distention (hydroplasty): a case series of patients with 'frozen shoulders' treated in a primary care office.

Halverson L, Maas R. J Fam Pract. January 2002. Vol.51. No.1. p.61-3.
Reviewed by Dr Bruce Adlam

Review: I include this small uncontrolled trial because it introduces a therapy I had not heard of previously. 'Frozen shoulder', most often caused by adhesive capsulitis, is frequently treated with intra-articular steroid injections, physical therapy, and surgical manipulation under anesthesia. These therapies provide limited benefits. This therapy of hydraulic distension of the shoulder joint capsule (hydroplasty) may have the potential to provide rapid relief of pain and immediate improvement of shoulder function for patients with adhesive capsulitis. Hydroplasty is an office procedure where local anaesthetic and steroids are injected followed by up to 40 mls of cold saline.
Comment: Pain relief was immediate in half, three quarters reported pain relief at one week and ten of nineteen procedures (53%) produced enduring benefit of comfort, motion, and function for up to 55 months.

22-284 Corticosteroid injections and arthrocentesis.

Dooley P, Martin R. Can Fam Physician Med Fam Can. February 2002. Vol.48. p.285-92.
Reviewed by Dr Mike Lyons

Review: Reviews current standard practice for steroid injection of joints and soft tissue. Tables standard indications, complications and contraindications. Seven figures illustrate and annotate injection of shoulder, elbow, carpal tunnel, finger, trochanteric bursa, knee and ankle.
Comment: Standard fare - unless you have no access to similar pharmaceutical handouts. Original figures in colour and some detail will be lost in black/white photocopy.

22-285 The use of an antifibrosis agent to improve muscle recovery after laceration.

Fukushima K, Badlani N, Usas A, et al. Am J Sports Med. July-August 2001. Vol.29. No.4. p.394-402.
Reviewed by Dr C Hanna

Review: This paper reports the use of human recombinant decorin, a TGF-ß antagonist, in a mouse-model for muscle lacerations. Findings included enhanced muscle regeneration, reduced formation of fibrosis and improved muscle strength.
Comment: Muscle injuries are very common in sport and this group is working towards improving healing of muscle injury. They have already looked at immobilisation and suturing.

22-286 Meniscal allograft transplantation: two- to eight-year results.

Rath E, Richmond JC, Yassir W, et al. Am J Sports Med. July-August 2001. Vol.29. No.4. p.410-4.
Reviewed by Dr C Hanna

Review: This paper presents the two- to eight-year follow-up of 18 patients who underwent meniscal allograft treatment for uni-compartmental knee pain following total meniscectomy. Results indicate that pain is reduced, function improved, but not normalised, and that there is no progression of wear, but that the risk of re-tear is higher than normal.
Comment: The search for an ideal treatment for patients with significant meniscal pathology continues. This paper reviews one possible avenue.

22-287 Medial and lateral meniscal tear patterns in anterior cruciate ligament-deficient knees: A prospective analysis of 575 tears.

Smith JP, Barrett GR. Am J Sports Med. July/August 2001. Vol.29. No.4. p.415-9.
Reviewed by Dr C Hanna

Review: Reviews the pattern of meniscal tears (575) in 476 patients with ACL deficiency. Lateral meniscal tears are slightly more common in the acute setting (56%). Medial meniscal tears are more common in chronic ACL deficiency (up to 96%), and most of these are in the posterior horn (99.4%).
Comment: The important issues raised by this paper are the frequency of meniscal pathology associated with ACL deficiency, the mechanism of injury of the medial meniscus, and the significance of this on subsequent management.

22-288 Radiography led to improved patient satisfaction but

increased short term pain in patients with low back pain.

Feder G. Evidence-Based Medicine. September-October 2001. Vol.6. No.5. p.145.

Reviewed by Dr Bruce Arroll

Review: This study randomised patients to usual care or radiography in patients with low back pain for more than six weeks. At three months the pain and disability score was higher in the group that had x-rays. This had disappeared at nine months. Patients who had x-rays were more satisfied. (Original article reviewed: BMJ 2001 Feb 17; 322: 400-5)

Comment: The commentator states that we need to explain to our patients that x-rays are unlikely to be helpful. Perhaps we could inform them that a lumbar spine x-ray is 65 times the radiation of a chest x-ray. I have found this often puts patients off having an x-ray.

22-289 What is the most effective treatment for acute low back pain?

Harwood MI, Chang S-l. J Fam Pract. February 2002. Vol.51. No.2. p.118.

Reviewed by Dr Bruce Adlam

Review: Nonsteroidal anti-inflammatory drugs (NSAIDs) are more effective than placebo for pain relief in patients with acute low back pain (grade of recommendation: A). There is no consistent evidence that NSAIDs are more effective than paracetamol acetaminophen (grade: D). Muscle relaxants are effective for short-term relief of acute low back pain (grade: A), but there is no added benefit when they are used in combination with NSAIDs (grade: B). Advice to remain active speeds recovery compared with short-term bed rest (grade: A). There is no consistent evidence that epidural steroid injections are effective for acute low back pain (grade: D). Spinal manipulation or back exercises are no more effective than medications alone (grade: B).

Comment: NZ spends a fortune on allied health so this might need a closer look. The article states that performance of specific flexion or extension exercises was no more effective than analgesics. In a randomised, controlled trial (n = 321) to assess the effectiveness of formal physical therapy for acute low back pain, patients referred to physical therapy were more satisfied with their care than were patients given handouts on back exercises, even though disability and pain scores were unchanged. Evidence is insufficient to support the use of spinal manipulation in patients with acute low back pain because of serious design flaws in the trials. However, the AHCPR states that manipulation is safe and effective in the first month in patients who do not have radicular symptoms.

Neurology

22-290 Parkinson disease and its differentials: diagnoses made easy.

Chan DK. Aust Fam Physician. November 2001. Vol.30. No.11. p.1053-6.

Reviewed by Dr Barry Suckling

Review: Even for experienced clinicians, diagnostic accuracy is only about 80%. Although Parkinson disease is a common cause of Parkinsonism, other causes include drug reactions, benign essential tremor, vascular disease, and LBD (Lewy body dementia), an increasingly recognised condition.

Comment: Incorrect diagnosis can result in complications related particularly to the use of levodopa and antipsychotics.

22-291 Treatment of postherpetic neuralgia: A systematic review of the literature.

Alper BS, Lewis PR. J Fam Pract. February 2002. Vol.51. No.2. p.121-8.

Reviewed by Dr Bruce Adlam

Review: This review examined whether any treatment had been shown to reduce pain or disability from postherpetic neuralgia, a common sequela of herpes zoster in elderly patients. They found no single best treatment. Tricyclic antidepressants, topical capsaicin (Not available in NZ), gabapentin (newer anticonvulsant), and oxycodone (opioid analgesic) are effective for alleviating PHN. However, long-term, clinically meaningful benefits are uncertain and side effects are common. Patients with postherpetic pain, refractory to these therapies, may benefit from intrathecal methylprednisolone. Sympathetic blocks using bupivacaine or lidocaine were effective but the proportion of patients who improved significantly is not reported. Acupuncture showed no advantage over mock TNS except for brief relief in one small trial.

Comment: There was no word of topical aspirin in chloroform or diethyl ether. I am not sure why it was excluded. A Medline search on 'topical aspirin in postherpetic neuralgia' brings up a list of papers and although it's not the done thing to suggest a couple of papers after someone else has done a formal review, I include it here just in case you too thought you were going dotty. ('Topical aspirin/diethyl ether mixture versus indomethacin and diclofenac/diethyl ether mixtures for acute herpetic neuralgia and postherpetic neuralgia: a double-blind crossover placebo-controlled study'. Pain 1996 Apr; 65 (1): 45-5. De Benedittis G; Lorenzetti A, Pain Research and Treatment Unit, University of Milan, Italy.) There were similar results reported where the vehicle was chloroform, and vaseline intensive care lotion.

22-292 Evaluation and treatment of the adult patient with migraine.

Polizzotto MJ. J Fam Pract. February 2002. Vol.51. No.2. p.161-7.

Reviewed by Dr Bruce Adlam

Review: This is a wide-ranging article covering recognition and management of migraine based on the USHC evidence based guidelines targeted at primary care physicians. It contains tables and an algorithm of treatment options.

Comment: In the same journal there is a qualitative study which aims to identify the areas that people find most difficult in living with migraines (see 22-293) and, in that regard, what kinds of assistance would be most helpful to them and to other people who have migraine headaches. In a nutshell they want to understand more about them, what pain relief to use and an understanding physician. (See also 22-294)

22-293 Perceptions and needs of patients with migraine: A focus group study.

Cottrell CK, Drew JB, Waller SE, et al. J Fam Pract. February 2002. Vol.51. No.2. p.142-7.
Reviewed by Dr Bruce Adlam
Review: See 22-292.

22-294 Which oral triptans are effective for the treatment of acute migraine?

Chang L, Henley E. J Fam Pract. February 2002. Vol.51. No.2. p.176.
Reviewed by Dr Bruce Adlam
Review: See 22-292.

Nutrition

22-295 Obesity: the science behind the management.

Steinbeck K. Intern Med J. May/June 2002. Vol.32. No.5/6. p.237-41.
Reviewed by Dr Helen Moriarty
Review: A discussion paper from the metabolism and obesity services of Royal Prince Alfred Hospital, Sydney. This paper provides a classification for obesity, describes genetic components, summaries management approaches.
Comment: The prevalence of obesity is increasing. This is a good summary of the science behind the management. Could make a great basis for peer group discussion.

Obstetrics

22-296 Postpartum disorders in primary care: Diagnosis and treatment.

Gold LH. Prim Care. March 2002. Vol.29. No.1. p.27-41.
Reviewed by Dr M Hewitt
Review: Depression and psychosis in the florid state are easy to recognise and provide treatment for. The author describes some of the more subtle presentations and includes the Edinburgh Postnatal Depression Scale (EPDS) in the appendix.
Comment: A helpful scale which can be a useful tool in the detection of early depressive changes.

22-297 Outcomes at three months after planned cesarean vs planned vaginal delivery for breech presentation at term: The International randomized term breech trial.

Hannah ME, Hannah WJ, Hodnett ED, et al. JAMA. 10 April 2002. Vol.287. No.14. p.1822-31.
Reviewed by Dr Len Brake
Review: There is significant reduction in adverse perinatal outcomes with planned LSCS for breech presentation but this carries a slightly increased maternal morbidity. This follow up study compares maternal outcomes at three months post partum. Women in the planned LSCS group were less likely to report urinary incontinence but other outcomes were not significantly different.

Occupational Health

22-298 Occupational health – a breath of fresh air.

Brown-Haysom J. Safeguard. May/June 2002. No.73. p.42-4.
Reviewed by Dr Michael Kahan
Review: A review of airborne hazards (e.g. dusts, fumes, gases and vapours) and ways to minimise the risks of exposure. The article covers how to do an assessment in the workplace, using the principles of elimination and isolation, before respiratory protection and advice on the importance of a respiratory programme. The respiratory protection must fit properly, be stored correctly and be replaced regularly.
Comment: A good overall summary of ways to reduce airborne contaminants in the workforce. Useful for GP's involved in occupational health issues.

Orthopedics

22-299 Management of common stress fractures: When to apply conservative therapy, when to take an aggressive approach.

Perron AD, Brady WJ, Keats TA. Postgrad Med. February 2002. Vol.111. No.2. p.95-106.
Reviewed by Dr Chris Milne
Review: Stress fractures can be diagnosed and treated by GPs in a straightforward manner. However, certain stress fractures (e.g. Jones fracture of 5th metatarsal), anterior tibial stress fractures, plus those involving the femoral neck or low back are prone to serious complications. In these cases, or any where the GP is uncertain about management, referral to an orthopaedic surgeon or sports physician is recommended.
Comment: Useful article. I agree with most recommendations, but the authors recommendation of a wooden soled shoe for metatarsal stress fractures is not my practice. Instead, refer to a podiatrist as orthotics may help recovery.

Paediatrics

22-300 Randomised controlled trial of behavioural infant sleep intervention to improve infant sleep and maternal mood.

Hiscock H, Wake M. BMJ. 4 May 2002. Vol.324. No.7345. p.1062-7.
Reviewed by Dr Len Brake
Review: A Melbourne study with 156 mums of infants aged six months to 12 months with severe sleep problems. In effect this study checks out whether a controlled crying technique works. Short answer: Yes - with consequentially less depression which was maintained on follow-up.
Comment: An excellent, practical down to earth study.

22-301 Effect of routine zinc supplementation on pneumonia in

children aged six months to three years: randomised controlled trial in an urban slum.

Bhandari N, Bahl R, Taneja S, et al. BMJ. 8 June 2002. Vol.324. No.7350. p.1358-61.

Reviewed by Dr Len Brake

Review: This study evaluates the effect of daily zinc supplementation on the incidence of pneumonia. It is a well-designed trial on 2482 children aged six months – 30 months in a New Delhi slum area. Zinc 10–20mg or placebo was given daily and all children had a massive dose of vitamin A on enrolment. Results: 81 cases pneumonia in zinc group and 112 in placebo group.

Comment: Interesting - it may be of interest of course to peruse the zinc levels of children in some areas of this country maybe.

Practice Management

22-302 Transferring medical records: Improving the exchange.

Faloon T, Dermer M, Pelletier S, et al. Can Fam Physician Med Fam Can. March 2002. Vol.48. p.563-7.

Reviewed by Dr Mike Lyons

Review: Comment in patient management section of the journal on current practices in Canada. Exhorts doctors to be more specific in requesting transfer of new patient records after interviewing the patient. Has a formatted letter with eleven tick box options. Has a second letter to patients to outline options and charges.

Comment: Have not seen this in New Zealand yet – but last month I had a request from Queensland for $28 before my letter requesting past medical records would be addressed. It went on to inform me that specialist reports and lab results would have to be requested directly from source. Caveat emptor indeed!

22-303 Legible charts! Experiences in converting to electronic medical records.

Haskins M. Can Fam Physician Med Fam Can. April 2002. Vol.48. p.768-71.

Reviewed by Dr Mike Lyons

Photo: Michael Long

Review: Described the process from July 1998 whereby six salaried rural family practitioners in British Columbia converted from paper to computer. Outlines needs assessment, hardware and software requirements, staff consensus, attitude to change and ongoing flexibility and maintenance.

Comment: Useful skeleton outline for those considering computerisation for the first time. More detailed needs will emerge as the process develops. None of the New Zealand software packages are mentioned.

Preventive Medicine and Screening

22-304 Vaccines for HIV in the developing world.

Kent SJ. Intern Med J. April 2002. Vol.32. No.4. p.136-7.

Reviewed by Dr Helen Moriarty

Review: A short commentary paper that describes the current approaches to HIV vaccine design and explains the practical and ethical problems that this development raises.

Comment: A good read, and thought-provoking.

22-305 A randomised trial of population screening for melanoma.

Aitken JF, Elwood JM, Lowe JB, et al. J Med Screen. 1 March 2002. Vol.9. No.1. p.33-7.

Reviewed by Dr Bruce Arroll

Review: This study was part of a randomised controlled trial examining screening for melanoma by self examination and examination by a doctor. There will be a wait of 15 years for the mortality data but already the screening group have had a significant 2.5 increase in participation compared with the control population.

Comment: While we need to await the results of this study to see if screening will save lives it would be cautious to do a full check of patients' skin although it is not clear at what intervals this should be done.

22-306 Probabilities of progression of aortic aneurysms: estimates and implications for screening policy.

Couto E, Duffy SW, Ashton HA, et al. J Med Screen. 1 March 2002. Vol.9. No.1. p.40-2.

Reviewed by Dr Bruce Arroll

Review: This study was part of a randomised controlled trial examining screening for aortic aneurysm. Normal is considered to be under 30 mm. They found that screening intervals should be progressively shorter for patients older than seventy years (men only). Active follow up is recommended for men with an aortic diameter of 45-54 mm.

Comment: We need to await the results of this study to see if screening will save lives. In the meantime we should perhaps be monitoring those more closely with abnormal diameters and consider for surgery those with diameters 55mm or over.

22-307 Is prostate-specific antigen (PSA) screening indicated for any subgroup of men?

Fisher M, Beck E. J Fam Pract. February 2002. Vol.51. No.2. p.113.

Reviewed by Dr Bruce Adlam

Review: The evidence based answer indicates that there are still no well-designed randomised controlled trials available that show PSA testing improves mortality or quality of life

for any specific group of men. A trend toward detecting more localized cancers and a possible decreasing mortality rate from Cancer of the Prostate in all men may be related to PSA testing, lead-time bias, or both. (Grade of recommendation: C) Two well-designed randomized controlled trials will report results in 2004. Recommendations for practice: The US Preventive Services Task Force in 1996 recommended against performing routine screening, stating that there was fair evidence to exclude the test. The American Cancer Society and the American Urological Association recommend that PSA be offered annually, beginning at patient age 50, to men with a life expectancy of more than 10 years similarly to those 40-45 at higher risk (e.g. Afro-American/first degree relative with Ca prostate).

Procedures and Techniques

22-308 Emergency case: Reducing anterior shoulder dislocation: Easy is good.

Schubert H. Can Fam Physician Med Fam Can. March 2002. Vol.48. p.469-72.
Reviewed by Dr Mike Lyons

Review: Describes 'two quick, easy, and highly effective methods' of reducing shoulder dislocations - with photos. One is the external rotation method and the other scapular manipulation.

Comment: May be helpful for those of us with little experience of success with Kocher manoeuvre or Hippocratic method. Why does it all seem so easy when reading?

22-309 Validation of the Ottawa Knee Rules.

Emparanza JI, Aginaga JR. Ann Emerg Med. October 2001. Vol.38. No.4. p.364-8.
Reviewed by Dr Mike Slatter

Review: A prospective cohort study from Spain found the Ottawa Knee Rules to be 100% sensitive for fracture of the knee.

Comment: Good study confirming the usefulness of the Ottawa Knee Rules as a clinical prediction instrument. Important to know these rules when deciding on whether to X-ray an injured knee.

Psychiatry and Psychology

22-310 Depression and anxiety in older women.

Goldstein MZ. Prim Care. March 2002. Vol.29. No.1. p.69-80.
Reviewed by Dr M Hewitt

Review: The author recommends a holistic approach because her consideration is that depression and anxiety are comorbid conditions in older women. The reasons are many, such as a history of abuse (elder, sexual, violent) and the presence of serious end-of-life disease states. An overall assessment means the use of non-pharmacological interventions will contribute as much to the relief of anxiety and improved quality of life as pharmacological interventions.

Comment: Such a consideration equally applies to men, although in this age group there are fewer of them.

22-311 Eating disorders: A guide for the primary care physician.

Powers PS, Santana CA. Prim Care. March 2002. Vol.29. No.1. p.81-98.
Reviewed by Dr M Hewitt

Review: The author describes the diagnostic criteria for eating disorders and then discusses effective treatments and strategies for implementing them. It is important to recognise these conditions early and maintain follow-up.

Comment: Behavioural strategies work best and SSRIs are shown to be ineffective in underweight patients. This is thought to be due to the lack of tryptophan as a result of inadequate carbohydrate intake.

22-312 Effect of Hypericum perforatum (St John's wort) in major depressive disorder: A randomized controlled trial.

Hypericum depression trial study group. JAMA. 10 April 2002. Vol.287. No.14. p.1807-14.
Reviewed by Dr Len Brake

Review: The study used a placebo control and sertraline as an active comparator. After eight weeks of treatment, change from the baseline Hamilton Depression scale was not significantly different from placebo in either the St John's wort or the sertraline group. The placebo response is discussed. All studies analysed showed a substantial placebo response and interestingly this response is increasing over recent years. See also the review 22-313 and the editorial 22-314.

22-313 Placebo response in studies of major depression: Variable, substantial, and growing.

Walsh BT, Seidman SN, Sysko R, et al. JAMA. 10 April 2002. Vol.287. No.14. p.1840-7.
Reviewed by Dr Len Brake

Review: See 22-312 and 22-314.

22-314 Placebo in clinical trials for depression: Complexity and necessity.

Kupfer DJ, Frank E. JAMA. 10 April 2002. Vol.287. No.14. p.1853-4.
Reviewed by Dr Len Brake

Review: See 22-312 and 22-313.

22-315 Dementia: strategies for caring.

Sturmberg, JP, Mason B, Kane M. Aust Fam Physician. November 2001. Vol.30. No.11. p.1061-4.
Reviewed by Dr Barry Suckling

Review: 'What does it matter if he can't remember his grandchildren, as long as they can remember him'.

Comment: A good review of strategies relating to the patient, the patients carer and the involvement of community services. Contains a simple sheet for carer education 'tips for carers'.

22-316 Posttraumatic stress disorder: Safe, effective management in the primary care setting.

Khouzam HR, Donnelly NJ. Postgrad Med. November 2001. Vol.110. No.5. p.60-78.
Reviewed by Dr Chris Milne

Review: Originally observed as a disorder among military combat veterans, post traumatic stress disorder is known to affect people from all walks of life. Following the terrorist attacks

of 11th September, 2002, awareness of the disorder was heightened. A variety of stressors, including criminal assault, serious accident, sexual or physical abuse, or witnessing such events, can trigger the disorder. Pharmacologic agents used include antidepressants, mood stabilisers (e.g. lithium, carbemazepine) and anxiolytics.
Comment: Readable article about a complex topic. The only management intervention discussed is pharmacologic, whereas this is only one component of a range of therapies for this condition. Useful patient notes (attached).

Respiratory System

22-317 When to suspect obstructive sleep apnea syndrome: Symptoms may be subtle, but treatment is straightforward.

Attarian HP, Sabri AN. Postgrad Med. March 2002. Vol.111. No.3. p.70-6.
Reviewed by Dr Chris Milne
Review: Partial or complete obstruction of the upper airway during sleep affects 2% of women and 4% of men. The most common symptoms are snoring, daytime sleepiness, and witnessed apnoeic episodes. Always try to get a corroborative history from the patients partner. Serious consequences include falling asleep at the wheel, and car crashes. Sleep laboratories are operating in major centres in New Zealand and the nocturnal polysomnogram is the diagnostic procedure of choice.
Comment: Although CPAP (continuous positive airways pressure) is the primary therapy recommended by these authors, there are some patients who don't tolerate it well.


Photo: Michael Long

22-318 Prevalence of snoring and sleep-disordered breathing in a group of commercial bus drivers in Hong Kong.

Hui DS, Chan JK, Ko FW, et al. Intern Med J. April 2002. Vol.32. No.4. p.149-57.
Reviewed by Dr Helen Moriarty
Review: An interesting study of 216 bus drivers. This showed a high prevalence of snoring or other sleep disordered breathing. This has major implications for work performance and public safety. Daytime sleepiness was a major consequence. Many were overweight.
Comment: Driving is a sedentary occupation, but one requiring intense concentration. A similar study of rail engine drivers in NZ showed similar conclusions. This is (another) preventive health issue for GPs to take to heart.

22-319 Can patients hospitalized with community-acquired pneumonia be treated safely and effectively with oral antibiotics?

Maughan K. J Fam Pract. February 2002. Vol.51. No.2. p.110.
Reviewed by Dr Bruce Adlam
Review: Answer = Yes. IV antibiotics need not be given for non-severe pneumonia. In patients with severe pneumonia, starting treatment with IV antibiotics and switching to oral therapy after two days resulted in the same outcomes as did 10 days of IV antibiotics. (Original article reviewed: Am J Med 2001; 111: 367-74).

Rheumatic Diseases

22-320 Non-prescription complementary treatments used by rheumatoid arthritis patients attending a community-based rheumatology practice.

Buchbinder R, Gingold M, Hall S, et al. Intern Med J. May/June 2002. Vol.32. No.5/6. p.208-14.
Reviewed by Dr Helen Moriarty
Review: A phone questionnaire of patients from a suburban Melbourne rheumatology practice revealed that over 80% of patients with rheumatoid arthritis have used some type of complementary medicine - mainly dietary. Patients spend as much on these as on prescription medicine, but perceive that less benefit is obtained from the complementary medicine.
Comment: The paper did not explore why patients spend money on complementary medicine. This is a research project crying out to be done in general practice.

Sexually Transmitted Diseases

22-321 10-minute consultation: Genital herpes.

Oakeshott P, Hay P. BMJ. 4 May 2002. Vol.324. No.7345. p.1076.
Reviewed by Dr Len Brake
Review: A young woman returns for a swab result for 'cold sore virus' is the subject in this one of a series. Nicely understated and up to date. A statement such as: 'Explain that genital herpes is common and relatively harmless' has to be that of an experienced general practitioner.
Comment: Another in this series of extremely practical information with key points and useful reading files.

Sports and Sports Medicine

22-322 Summary and agreement statement of the first International Conference on Concussion in Sport, Vienna 2001. Recommendations for

the improvement of safety and health of athletes who may suffer concussive injuries.

Aubry M, Cantu R, Dvorak J, et al. Br J Sports Med. February 2002. Vol.36. No.1. p.6-10.

Reviewed by Dr Chris Milne

Review: This article consists of a revised definition of concussion, clinical symptoms and signs, description of neuropsychological assessment after concussion, the role of neuroimaging (minimal at present), plus a return to play protocol. In efforts to prevent concussion, mention is made of preventive strategies, including neck muscle conditioning (useful), helmets and mouth guards (no clinical evidence in preventing concussion).

Comment: A timely contribution. The ten authors are drawn from varied backgrounds, and have put together a 'state of the art' article. It should be read by anyone who sees a reasonable number of concussed athletes.

22-323 New criteria for female athlete triad syndrome?

Khan KM, Lui-Ambrose T, Sran MM, et al. Br J Sports Med. February 2002. Vol.36. No.1. p.10-3.

Reviewed by Dr Chris Milne

Review: The original definition of female athlete triad was of a 'serious syndrome consisting of disordered eating, amenorrhoea and osteoporosis'. Since 1994 the term osteoporosis has gone from a generalised description of reduced bone density to a specific descriptor based on Dual Energy X-ray Absorptiometry (DEXA) scanning (bone mineral density (BMD) of more than two to five standard deviations below the mean of young adults). The authors argue that the definition of the female athlete triad should be modified to include osteopenia (BMD of 1.0-2.5 standard deviations below the mean of young adults).

Comment: I'd agree with the authors, as the current definition, when applied to strictly defined DEXA scan scores, excludes the majority of athletes suffering ill health due to excessive exercise and a distorted body image.

22-324 Banning pregnant netballers – is this the answer?

White S. Br J Sports Med. February 2002. Vol.36. No.1. p.15-6.

Reviewed by Dr Chris Milne

Review: In 2001, Netball Australia placed a ban on all pregnant netballers participating in their sport. The move was accompanied by widespread media coverage at the time. Since then, the Australian Sports Commission held a national forum with a range of experts and interested parties invited to contribute. Current available evidence suggests that sport and exercise, if anything, has a beneficial effect on the fetus/child.

Comment: Useful contribution to an important debate. It exemplifies the notion that all sporting bodies should be careful to avoid knee-jerk reactions to perceived risks and consult with recognised experts. In this era of evidence-based medicine, rational responses to complex problems may arise.

22-325 Management of the sprained ankle.

van Dijk CN. Br J Sports Med. April 2002. Vol.36. No.2. p.83-4.

Reviewed by Dr Chris Milne

Review: The most commonly injured ligament is the anterior talofibular ligament (ATFL). Complete ruptures of this structure can be reliably diagnosed clinically. A combination of a positive anterior drawer test with pain on palpation of the ATFL and haematoma discolouration has a sensitivity of 100% and specificity of 77%. The definitive examination can be safely delayed until four to five days post injury without disturbing wound healing. Non operative treatment with early functional rehabilitation is the treatment of choice.

Comment: For complete ruptures, I would recommend a McDavid type lace up brace rather than plaster cast. If conservative treatment fails, secondary reconstruction can be performed at a later date.

22-326 An examination of injuries in major league soccer: The inaugural season.

Morgan BE, Oberlander MA. Am J Sports Med. July/August 2001. Vol.29. No.4. p.426-30.

Reviewed by Dr C Hanna

Review: Reviews the injury data collected over all the teams involved in the inaugural major league soccer (professional) in the United States. Injury rates in training and game situations are reported (12 times as many injuries occur during games).

Comment: This is an interesting epidemiological paper which looks at injury rates in professional soccer.

Travel Medicine

22-327 Travel insurance.

Corke C. Aust Fam Physician. November 2001. Vol.30. No.11. p.1057-60.

Reviewed by Dr Barry Suckling

Review: Make sure you tell all! Travellers who take out insurance without disclosing existing medical conditions are wasting their money. They risk the insurance company not paying their costs. In this article there are salutary and awful stories, all based on true cases.

Comment: A good read. May make a good information sheet for patients who try to get you to 'stretch the truth'.

Urology

22-328 Knowledge, attitudes and experience associated with testing for prostate cancer: a comparison between male doctors and men in the community.

Livingston P, Cohen P, Frydenberg M, et al. Intern Med J. May/June 2002. Vol.32. No.5/6. p.215-23.

Reviewed by Dr Helen Moriarty

Review: Telephone interviews were conducted with male doctors over 49 years of age and male patients of the same age group. 55% of men knew that prostate disease is 'sometimes' cancer, 55% of male doctors believed men should be tested two yearly. The majority of male doctors who had been tested for prostate cancer had tested negative.
Comment: A promising title, but the paper does not go far enough. This paper focuses on figures, such as those quoted above rather than on reasons why testing is widespread, and reasons behind testing decisions.

Virus Diseases

22-329 Diagnosis and 10-year follow-up of a community-based hepatitis C cohort.

Yawn BP, Wollan P, Gazzuola L, et al. J Fam Pract. February 2002. Vol.51. No.2. p.135-40.
Reviewed by Dr Bruce Adlam

Review: This retrospective medical record review's objective was to determine the health care follow-up and treatment associated with physician-diagnosed hepatitis C (HCV) in a community-based population. In this community, follow-up and treatment related to HCV was limited. Attention to prevention of disease-accelerating co-infections was only modest. Referral or documented recommendations for treatment of alcoholism or heavy chronic alcohol ingestion were minimal.
Comment: The importance of this article lies not so much in its lacklustre findings but more in primary care physicians 'lack of a uniform or aggressive approach to HCV infections'. This is not surprising in view of the wide disparity of available information on chronic HCV infection and its progression to symptomatic or progressive liver disease. Unfortunately, progression to chronic HCV infection cannot be predicted from initial clinical or laboratory factors.

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