Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Ann Emerg*
Ann Intern Med*
BMJ*
Br J Sports Med*
Brain Behav Immun*
Can Fam Physician Med Fam*
Drug Alcohol Rev*
J Fam Pract*
JAMA*
Lancet*
N Engl J Med*
New Zealand Journal of Sports Medicine
Patient Care*
Postgrad Med*
Prim Care*
Safeguard

* Journals indexed in Medline

Acupuncture

23-232 Acupuncture has no immediate treatment effect on the neutrophil respiratory burst: A randomized single-blinded two-period crossover study.

Karst M, Scheinichen D, Rueckert T, et al. Brain Behav Immun. December 2002. Vol.16. No.6. p.813-6.
Reviewed by Dr Alex Chan

Review: Respiratory burst (RB) of polymorphonuclear leucocytes is a measure of their phagocytic activity. In this study, the authors examined the effect on this reaction from bilateral acupuncture treatments on LI-11, using placebo needling in the control group. Needles remained in place for 30 minutes. The RB was determined before and 30 minutes after removal of needles. After two weeks, each group received the alternative treatment. No effect of acupuncture on the neutrophil RB was observed in either experiment.
Comment: Single treatment of LI-11 does not appear to have significant effect on polymorphonuclear cytotoxicity.

Alcohol and Substance Abuse

23-233 The relationship of conduct disorder to attempted suicide and drug use history among methadone maintenance patients.

Darke S, Ross J, Lynskey M. Drug Alcohol Rev. January 2003. Vol.22. No.1. p.21-5.
Reviewed by Dr Helen Moriarty

Review: An interview-based research protocol. One hundred and eighty-one methadone patients contributed to the data. Patients diagnosed with Conduct Disorder (CD) were younger and less educated than other methadone patients. CD patients were also more likely to have attempted suicide.
Comment: As GPs take on more methadone prescribing in their practice, a knowledge of psychiatric comorbidities will become helpful. A postgrad paper is available from the Otago University on Psychiatric Comorbidities, their assessment and treatment, and the National Opioid Treatment Training Programme runs short courses (details available through Goodfellow Unit, University of Auckland).

23-234 Patterns and correlates of substance use amongst juvenile detainees in New South Wales 1989-99.

Copeland J, Howard J, Keogh T, et al. Drug Alcohol Rev. January 2003. Vol.22. No.1. p.15-20.
Reviewed by Dr Helen Moriarty

journal review service

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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.

JRS Reviewers

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THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

Review: A national survey was conducted in 1997 of the mental wellbeing of Australians. This paper reports on regression analysis of alcohol use and other substances. Alcohol was strongly related to use of other substances: tobacco (51%), cannabis (32%), other drugs (15%). Comorbid substance abuse plus alcohol dependence predicted mental health disorders.
Comment: It is worth asking about other substances when enquiring about alcohol use. Traditionally, alcohol was not regarded as a 'gateway' drug leading to use of other things, but this paper questions that dogma.

Alternative Medicine

23-235 Ethical considerations of complementary and alternative medical therapies in conventional medical settings.

Adams KE, Cohen MH, Eisenberg D, et al.
Ann Intern Med. 15 October 2002. Vol.137. No.8. p.660-4.
Reviewed by Dr Mike Slatter
Review: This article examines the physician's ethical obligations when recommending, tolerating or prescribing complementary and alternative medical (CAM) therapies. Ethical obligations of non-abandonment, autonomy and commitment to joint problem solving are examined. Physicians are encouraged to remain engaged in problem solving with their patient and to attempt to elucidate and clarify the patients core values and beliefs when counselling about CAM therapies.
Comment: The authors provide a useful risk-benefit framework which can be used to determine the appropriateness of using CAM therapies in various clinical scenarios. The body of evidence regarding CAM therapies is growing and we need to be informed.

23-236 Herb-drug interactions: What physicians need to know.

Bonakdar RA. Patient Care. January 2003. Vol.37. No.1. p.58-69.
Reviewed by Dr Len Brake
Review: The sale of herbal supplements has increased by 400%. Whole supermarket aisles consist of 'herbal' product demonstrating yet again that 'there's one born every minute'. The safety of these nostrums both in themselves, and in combination with a patient's usual medication has consequently become more important to the GP. St John's Wort is the most common herb involved in interactions. Warfarin is the most common medical drug involved with herb reactions.
Comment: Could that puzzling INR be the result of a 'natural' herb?

23-237 Ginkgo is not a smart pill.

Lazar PA. J Fam Pract. November 2002. Vol.51. No.11. p.912.
Reviewed by Dr Bruce Adlam
Review: Answer = No, at least not in standard doses for six weeks. But not all products were tested and they do vary. Some might be effective but this should be enough for you to refrain from recommending it to your older patients worried about memory loss. (Original article reviewed: JAMA 2002; 288: 835–40)

Analgesia

23-238 Tips for managing chronic pain: Implementing the latest guidelines.

Marcus DA. Postgrad Med. April 2003. Vol.113. No.4. p.49-66.
Reviewed by Dr Chris Milne
Review: The authors describe various strategies, and include education as being particularly important. They recommend patients with chronic pain be thought of as similar to relatives – people who are part of our life as a result of circumstances beyond our control, but for whom we have been given responsibility. Recognising neuropathic pain, with its burning quality and associated hypersensitivity, and intervening appropriately is important.
Comment: A useful perspective on a difficult problem.

Asthma

23-239 Managing patients with high-risk asthma.

O'Hollaren M, Hartert T. Patient Care. January 2003. Vol.37. No.1. p.14-38.
Reviewed by Dr Len Brake
Review: The diagnosis 'asthma' has been stretched to include such a huge number of respiratory complaints, many a childhood cough has become labelled 'asthma' and almost every child who wheezes is now 'asthmatic'. Consequently it appears that the incidence is rising. I wonder though... Still, the severe brittle asthmatic is a frightening challenge and this update is one of the more helpful. Although I would not have thought that IM

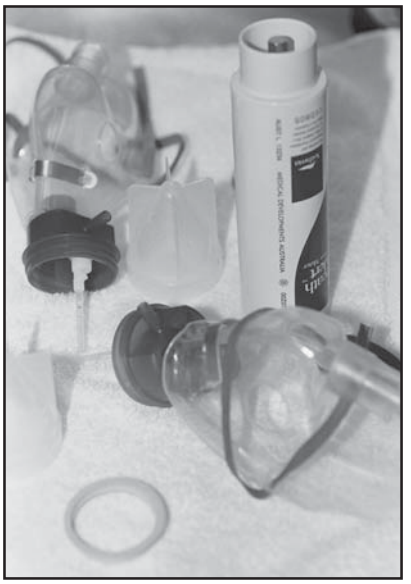

Photo: Michael Long

adrenaline is used as treatment of choice as often today as it was in days gone by.

Cardiovascular System

23-240 Can statins cause chronic low-grade myopathy?

Grundy SM. Ann Intern Med. 1 October 2002. Vol.137. No.7. p.617-8.
Reviewed by Dr Mike Slatter

Review: This editorial looks at the myopathy that can be associated with Statin use. There is some doubt as to the existence of a chronic low grade myopathy with normal creatine kinase levels in patients treated with Statins.

Comment: The Statins are now widely used and we need to be aware of the complication of myopathy. Withdrawal of treatment is certainly needed if the creatine kinase is raised. In patients with muscle symptoms but normal CK, cautious continuation of treatment is probably indicated especially in high-risk patients

23-241 Diagnosis, investigation, and management of deep vein thrombosis.

Tovey C, Wyatt S. BMJ. 31 May 2003. Vol.326. No.7400. p.1180-4.
Reviewed by Dr Len Brake

Review: Clinical diagnosis is notoriously unreliable. Homan's sign for example is a total waste of time, yet I would not be the only GP to have written 'Homan's negative' in notes of patients with a swollen leg. This is a helpful clinical review and the place of D-Dimers and ultrasound scans in diagnosis is well covered as are the treatments available.

Comment: The differential diagnosis list is a good reminder too!

23-242 Chronic stable angina: treatment options.

O'Toole L, Grech ED. BMJ. 31 May 2003. Vol.326. No.7400. p.1185-88.
Reviewed by Dr Len Brake

Review: One in the BMJ series of Interventional Cardiology. This is an excellent summary of treatments available in chronic angina. The decision between angioplasty and CABG is usually left in the hands of the cardiology/surgical team to be sure, and trials of medical treatment versus surgical options predates the widespread use of antiplatelet and cholesterol lowering drugs. Also the new drug coated stents are not included in trials but it's likely they will reduce the problem of re-stenosis.

Comment: A helpful knowledge update.

23-243 Echocardiography or auscultation? How to evaluate systolic murmurs.

Shub C. Can Fam Physician Med Fam Can. February 2003. Vol.49. p.163-7.
Reviewed by Dr Mike Lyons

Review: Main message is that echocardiography is not required for evaluation of innocent murmurs. Decries the gradual degradation of auscultation skills that is becoming increasingly apparent in training programmes – in one USA programme only 20% of abnormal heart sounds were correctly identified from auscultatory tapes. Economic forces constrained time for adequate physical examination leading to further erosion of clinical skills. Brief table on evaluation of systolic murmurs (not enough detail) and another on characteristics of benign systolic murmurs.

Comment: The final grave statement *'The future will decide whether the binaural stethoscope becomes a museum relic like its predecessor'* made me revise the cardiology chapter in my well thumbed Papworth's *A Primer of Medicine*.

23-244 Implementing the new ATP III cholesterol guidelines.

Cleeman JI, Davidson MH, Pasternak R. Patient Care. November 2002. Vol.36. No.13. p.19-31.
Reviewed by Dr Len Brake

Review: Let me précis this article: 'Keep the LDL cholesterol low and eat sensibly – End of story'. That's it. The alarm bells are triggered by the first sentence, *'The most critical advance in the new guidelines is the assigning of patients to one of three categories...'* How critical is that! From then on the article becomes repetitive and unhelpful. Check it out on www.patientcareonline.com if you don't believe me.

23-245 Who should be taking aspirin?

Hennekens C, Manson JE, Reilly M. Patient Care. November 2002. Vol.36. No.13. p.58-71.
Reviewed by Dr Len Brake

Review: The use of aspirin as primary prevention for CVS disease has been controversial. Early trials showed no benefit, but the US Preventive Service Task Force has recommended aspirin for primary prevention in patients 'at risk'. It is likely to be argued that 'all men over 50 years' should be included as their main risk group.

Comment: An interesting article with some informative updates.

23–246 The metabolic syndrome: A new focus for lifestyle modification.
Szapary PO, Hark LA, Burke FM. Patient Care. November 2002. Vol.36. No.13. p.75–88.
Reviewed by Dr Len Brake
Review: Fat people, especially those with a fat guts, often have insulin resistance, this in turn may lead to high blood pressure, lipid problems and diabetes. This combination is now called the Metabolic Syndrome (previously known as Metabolic Syndrome X).
Comment: Many pages detailing how fat people must eat well and exercise all the time and eat five helpings of fruit and veges every day. Nothing new. The optimistic or deluded author says *'by focusing on lifestyle..., clinicians will be able to reduce the burden of diabetes and cardiovascular diseases in the years to come'*. Yeah, right.

23–247 Invasive therapy for peripheral vascular disease.
Smith JA. Patient Care. December 2002. Vol.36. No.14. p.13–25.
Reviewed by Dr Len Brake
Review: Three case histories used to illustrate need for angiography, best candidates for angioplasty and stent placement, and how to recognise renal artery atherosclerosis.
Comment: I found this article readable and helpful. But then I did need a freshen up on the topic.

23–248 Update on therapy for acute and chronic heart failure: Applying advances in outpatient management.
Almeda FQ, Hollenberg SM. Postgrad Med. March 2003. Vol.113. No.3. p.36–48.
Reviewed by Dr Chris Milne
Review: The use of low dose ß-blockers and spironolactone are two advances in heart failure therapy in recent years. These authors advise against use of diuretics alone in the treatment of chronic heart failure. They recommend digoxin for those patients who remain symptomatic despite treatment with ACE inhibitors and ß-blockers, and in patients with both heart failure and atrial fibrillation who require control of the ventricular rate.
Comment: Useful summary article for registrars who want this information in an easily digestible form, plus more senior doctors who have witnessed the ebb and flow of opinion about digoxin over the years.

23–249 Do antioxidants (vitamins C, E) improve outcomes in patients with coronary artery disease?
Bloom OJ, Scoville C. J Fam Pract. November 2002. Vol.51. No.11. p.978.
Reviewed by Dr Bruce Adlam
Review: Antioxidant supplements of vitamins E and C do not reduce cardiovascular death in patients with cardiovascular disease. Two studies suggest vitamin E may reduce the incidence on non-fatal MI. Combinations of E, C, and Carotene do not decrease mortality or incidence of major coronary and vascular events.
Comment: This 2002 review of high quality studies concludes that antioxidant vitamin supplements cannot be recommended in the primary or secondary prevention of cardiovascular disease (Grade A1 high quality RCT).

23–250 Effects of comprehensive lifestyle modification on blood pressure control: Main results of the PREMIER Clinical Trial.
Writing Group of the PREMIER Collaborative Research Group. JAMA. 23/30 April 2003. Vol.289. No.16. p.2083–93.
Reviewed by Dr Raina Elley
Review: This randomised-controlled trial among 810 adults with mildly raised blood pressure (BP), assessed the effectiveness of an intensive lifestyle intervention, including weight-loss, sodium reduction, increased physical activity and limited alcohol intake, in reducing blood pressure over six months (Apparently, one-third of BP related deaths from coro-

nary heart disease are estimated to occur in individuals with a mildly elevated systolic BP of 120–139mm Hg or diastolic of 80–89mm Hg). The control group received brief dietary and lifestyle advice. A third arm received the lifestyle intervention plus specific advice about the DASH diet, which emphasises consumption of fruits, vegetables, low-fat dairy products, whole grains, poultry, fish and nuts. (The DASH diet alone has been shown previously to lower blood pressure). All three groups decreased their blood pressure, with the lifestyle intervention group decreasing systolic blood pressure by 3.7mm Hg more than the control, and the lifestyle plus DASH, by 4.3mm Hg more than the control ($p<0.01$). The difference between the two intervention groups was not significant. The prevalence of hypertension also went down compared with the control in each of the intervention groups. (The actual reduction in systolic BP from baseline were 6.6mm Hg for the control group, 10.5mm Hg in the intervention group, and 11.1mm Hg in the lifestyle plus DASH group).

Comment: The study was well designed and used blinded assessors. The fact that the brief advice group (control) also improved their lifestyle and BP made it difficult to demonstrate large changes with the interventions. The improvement in the control group may reflect the fact that brief advice is also effective in changing behaviour. Alternatively, it may reflect the fact that the study population consisted of mostly motivated volunteers who were keen to change anyway, or general awareness of lifestyle issues in the community increased, producing improvements in everyone. This study reiterates the potential for blood pressure control with lifestyle interventions. The fact that no matter which of these lifestyle components you change, blood pressure reduction is similar, but when combined, is not additive, raises some interesting questions, which are discussed in an accompanying editorial published in the same edition. (See 23-251)

23-251 Lifestyle modification and blood pressure control: Is the glass half full or half empty?'

Pickering TG. JAMA. 23/30 April 2003. Vol.289. No.16. p.2131-2.

Reviewed by Dr Raina Elley

Review: This editorial discusses the evidence for lifestyle behaviour change improving blood pressure. Weight-loss, dietary change, sodium reduction, physical activity, and alcohol reduction all reduce blood pressure, but when combined the effects are not totally additive (known as 'sub-additivity of intervention effects'). Two possible explanations are that people can only change one lifestyle factor at a time. Alternatively, the physiological mechanism of action for lowering blood pressure may be the same for these different lifestyle changes. An analogy would be that doubling the dose of an antihypertensive often only produces a small improvement, while adding a low dose of another antihypertensive with a different mechanism of action, can produce much greater reductions. The authors also suggest that the issue most important to focus on is weight reduction (for those overweight), as this is the factor most likely to reduce risk.

Comment: See also 23-250.

23-252 Long-term, low-intensity warfarin therapy for the prevention of recurrent venous thromboembolism.

Ridker PM, Goldhaber SZ, Danielson E, et al. N Engl J Med. 10 April 2003. Vol.348. No.15. p.1425-34.

Reviewed by Dr Raina Elley

Review: This is a very interesting trial of long-term low-dose warfarin maintenance (INR 1.5-2.0) versus placebo, amongst patients who had already received three to 12 months of full-dose warfarin (INR 2.0–3.0) after an idiopathic venous thromboembolic event. The outcomes of the trial were recurrent venous thromboembolism, major haemorrhage, and death. The trial had been designed to enrol 750 patients with an average follow-up of four years. However, the trial was terminated after only 508 patients had been enrolled and followed for an average of 2.1 years, because of obvious benefit without significant major adverse effects of the low-dose warfarin. Recurrent venous thromboembolic events were seen in 37/253 (7.2 per 100 person-years) of the placebo group compared with 14/255 (2.6 per 100 person-years) of the low-dose warfarin group ($p<0.001$). Although there were significantly more minor bleeds or bruising in the low-dose warfarin group, there was no significant difference in major bleeds or deaths. The composite endpoint showed significant net benefit.

Comment: This article is worth reading. Subgroup analyses were also done for groups such as those with inherited thrombophilia, which also showed a similar benefit. The implication is that following three to 12 months of full-dose warfarin for idiopathic thromboembolism, there is still a high risk of recurrent thromboembolic event. We should therefore be considering long-term low-dose warfarin treatment, as this is very effective at lowering risk of recurrent thromboembolism, without significant increases in major adverse events.

Cerebrovascular System

23-253 In patients with a previous CVA, do antioxidants protect against subsequent stroke?

Spencer DC, Meadows SE. J Fam Pract. November 2002. Vol.51. No.1. p.976.

Reviewed by Dr Bruce Adlam

Review: Most recent RCTs have not been able to confirm earlier observational studies of a benefit in antioxidants (vitamin C, E, Beta carotene) for preventing cardiovascular disease including stroke. No studies assessed only stroke patients. This is quite a good summary of the major trials.
Comment: Some authors claim failure to demonstrate benefit is due to inadequate antioxidant dosage, treatment length, or type of antioxidant.

Communicable Diseases, Infections and Parasites

23-254 Skin and subcutaneous infections.

Bhumbra NA, McCullough SG. Prim Care. March 2003. Vol.30. No.1. p.1-24.
Reviewed by Dr M Hewitt
Review: Most of the micro-organisms such as bacteria, fungi and viruses are reviewed with the problems caused by their penetration of our protective coating. From the surface to the systemic, this article covers the effects.
Comment: Or from A (Angina, Ludwig's) to Z (Zoonoses).

23-255 Microbiology and management of human and animal bite wound infections.

Brook I. Prim Care. March 2003. Vol.30. No.1. p.25-39.
Reviewed by Dr M Hewitt
Review: A description of the flora and transfer from the host to the victim and the variety of species and complications of the infections involved. Rare events are mentioned.
Comment: The basics of debridement and wound toilet remain the most important aspect of initial care. Advances in anti-microbial therapy are only secondary to this.

23-256 Urinary tract infections.

Bass PF, Jarvis JA, Mitchell CK. Prim Care. March 2003. Vol.30. No.1. p.41-61.
Reviewed by Dr M Hewitt
Review: These are common infections in primary care with regard to presentation. The authors describe and advise regarding best management including those UTIs occurring in children and pregnant women.
Comment: Useful also in regard to the management of common UTIs in catheter patients.

23-257 Gastroenteritis and antibiotic-associated diarrhea.

Jabbar A, Wright RA. Prim Care. March 2003. Vol.30. No.1. p.63-80.
Reviewed by Dr M Hewitt
Review: A careful review of origin, diagnosis, treatment and prevention of common causes of gastroenteritis presenting in primary care. In particular, the greater prevalence of antibiotic induced gastroenteric complications are discussed.
Comment: Not without good reason is a troublesome organism called 'difficile'.

23-258 Hepatitis.

Marsano LS. Prim Care. March 2003. Vol.30. No.1. p.81-107.
Reviewed by Dr M Hewitt
Review: A good discussion and evaluation of the Hepatides A, B, C, D and E. Also on best management in current practice and chronic carrier status patients.
Comment: Certainly relevant in NZ setting with B and C.

23-259 The laws of acute otitis media.

Harrison CJ. Prim Care. March 2003. Vol.30. No.1. p.109-35.
Reviewed by Dr M Hewitt
Review: A good review of the change in current clinical practice for best management of acute otitis media. In particular the evidence-based studies for not prescribing antibiotics at all.
Comment: Compelling and challenging reading for one of general practice's most common paediatric consultations.

23-260 Rhinosinusitis.

Winstead W. Prim Care. March 2003. Vol.30. No.1. p.137-54.
Reviewed by Dr M Hewitt
Review: A common condition with high prevalence in primary care presenting for treatment. The article reviews pathophysiology, investigation available, and current best management.
Comment: Antibiotics are not always the answer.

23-261 Community-acquired pneumonia in adults.

Ramirez JA. Prim Care. March 2003. Vol.30. No.1. p.155-71.
Reviewed by Dr M Hewitt
Review: Careful analysis of the condition in regard to treatment decisions and management. What is best to use in the way of antimicrobials and when to treat in hospital are discussed.
Comment: Good learning.

23-262 HIV disease in primary care.

Frame PT. Prim Care. March 2003. Vol.30. No.1. p.205-37.
Reviewed by Dr M Hewitt
Review: The author discusses the appropriate role of the primary care physician in the management of HIV/AIDS patients.
Comment: Services and facilities which exist in our community appear to be more available and better funded than what appears to be the case in the US.

Contraception and Family Planning

23-263 Emergency contraception.

Grimes DA, Raymond EG. Ann Intern Med. 6 August 2002. Vol.137. No.3. p.E180-9.
Reviewed by Dr Mike Slatter
Review: This article is a thorough discourse on this subject built around a case presentation. Discusses mode of action and indications. Progestin

only regimen is preferred as it is more effective and causes less nausea and vomiting. It prevents 85% of pregnancies and has no known medical contraindication except pregnancy. It is distinct from medical abortion and cannot interrupt an established pregnancy. Emergency insertion of IUCDs is also discussed.
Comment: Interestingly the 72-hour time limit should be seen as a guideline only and treatment should not be withheld from those who present later. Good comprehensive review.

Ear, Nose and Throat

23-264 A three-pronged approach to tinnitus.

Balkany TJ, Breener GB, House JW, et al. Patient Care. December 2002. Vol.36. No.14. p.40-9.
Reviewed by Dr Len Brake
Review: Tinnitus is a common enough presenting complaint and the differential diagnosis covers a range from wax in the ear canal to imminent death. The article covers clinical assessment and includes a summary of treatments available.
Comment: A helpful tying together of facts.

23-265 Screening and management of adult hearing loss in primary care: Scientific review.

Yueh B, Shapiro N, MacLean CH, et al. JAMA. 16 April 2003. Vol.289. No.15. p.1976-85.
Reviewed by Dr Raina Elley
Review: This is an excellent review of the literature. Hearing loss has a high and worsening prevalence (25–40% >65 years) and has an association with depression and functional decline. Treatment improves quality of life. The condition is underdiagnosed and under-treated. Therefore, screening is appropriate in primary care. Although most hearing loss is sensori-neural (e.g. due to presbycusis), up to 30% of hearing loss is due to, or exacerbated by, cerumen impaction or chronic otitis media, both treatable in primary care. The most reliable tests for hearing loss are use of an 'audioscope' (combination of otoscope and audiometer), and a self-administered questionnaire, the Hearing Handicap Inventory for the Elderly-Screening version (HHIE-S). Both these methods have good sensitivity and specificity when compared with formal hearing testing. This article provides good summaries of the epidemiology and physiology of hearing loss, screening techniques, and management. Some of the management issues addressed include non-compliance with hearing aids, sudden hearing loss, and potential ototoxicity of every-day medications, such as aspirin, erythromycin and loop diuretics. (Patient page attached.)
Comment: A copy of the HHIE-S and instructions for interpretation are included in the article. This article is evidence-based and helps raise awareness of a common treatable problem. Examples of clinical applications are included in an article in the same edition (see also 23-266). The screening tool and the instructions for interpretation are included in the article.

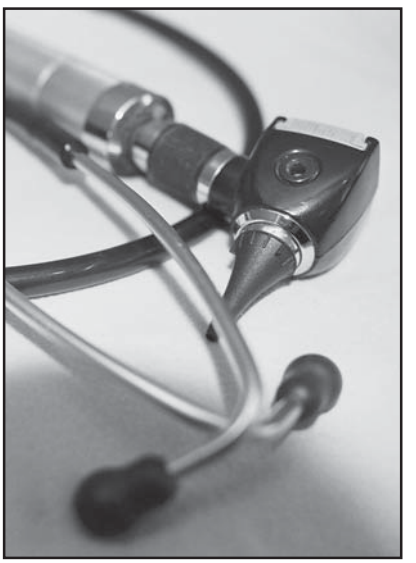

Photo: Michael Long

23-266 Screening and management of adult hearing loss in primary care: clinical applications.

Bogardus ST, Yueh B, Shekelle PG. JAMA. 16 April 2003. Vol.289. No.15. p.1986-90.
Reviewed by Dr Raina Elley
Review: This article provides practical examples of how to screen and manage gradual hearing loss, sudden hearing loss, and problems with hearing device use and general deterioration over time. It also provides useful information about decibel levels of common environmental noises and a summary of hearing aid characteristics. Lastly, the article offers simple advice when communicating with people with hearing loss: choose a quiet environment, and speak low and slow, rather than raising the pitch, which is a common reaction.
Comment: See also 23-265.

Endocrinology

23-267 Outpatient insulin therapy in type 1 and type 2 diabetes mellitus.

DeWitt DE, Hirsch IB. JAMA. 7 May 2003. Vol.289. No.17. p.2254-64.
Reviewed by Dr Raina Elley
Review: This is a good overview of the literature of insulin use. Mimicking physiological secretion of insulin with new insulin regimes, particularly with the use of physiologic basal-prandial insulin and rapid-acting insulin analogues, has several advantages over older regimes. These include fewer episodes of hypoglycaemia, more flexibility for patients and improved HbA1c. The new regimes and devices will probably be more cost effective than older regimes, due to the reduction of complications and adverse events, despite their greater immediate cost. This article also discusses the major adverse effects of insulin, and ways to minimise these,

issues to do with insulin delivery and the types available, and the differences between physiologic and nonphysiologic insulin regimes. Evidence-based discussions about supplements and adjustments to insulin because of episodes of hyperglycaemia, self-monitoring, and the best regimes to use in type 1 and type 2 diabetes, are also very useful. (Patient page attached.)
Comment: This article is very practically orientated with tips about medication regimes and management, throughout. One potential bias is the fact that most of the studies available were sponsored by the pharmaceutical industry. An article about the clinical applications of the scientific review is also included in this JAMA edition. (See 23-268)

23-268 Using new insulin strategies in the outpatient treatment of diabetes: Clinical applications.
DeWitt DE, Dugdale DC. JAMA. 7 May 2003. Vol.289. No.17. p.2265-69.
Reviewed by Dr Raina Elley
Review: This article applies the information gathered from the scientific review, to clinical scenarios. These help to illustrate ways to use bedtime insulin with oral agents, basal-prandial insulin strategies, and new insulin analogues, to improve glycaemic control and reduce the incidence of hypoglycaemia.
Comment: See also 23-267.

Family Practice

23-269 Classification of medical errors and preventable adverse events in primary care: A synthesis of the literature.
Elder NC, Dovey SM. J Fam Pract. November 2002. Vol.51. No.11. p.927-32.
Reviewed by Dr Bruce Adlam
Review: Interesting article covering the current state of published research and offers a classification system of: (1) Preventable adverse events in primary care related to diagnosis, treatment and preventative services. (2) Process errors, divided into clinician, communication, administration and issues relating to processes with practice, insurance and regulatory infrastructure.

Gastroenterology

23-270 H pylori infection in patients taking long-term NSAID therapy.
Kim BH, Scheiman JM. Patient Care. January 2003. Vol.37. No.1. p.51-7.
Reviewed by Dr Len Brake
Review: This is a summary of recent articles on NSAID caused peptic ulceration. Not a lot of revelation and discussions in detail on COX 2 inhibitors is normal NSAIDs gloss over the fact that most of the patients involved would fare just as well on good old fashioned paracetamol. (Speaking personally.)
Comment: Where does H pylori fit with NSAID ulceration? Nobody knows.

Genetics

23-271 Gene expression predictors of breast cancer outcomes.
Huang E, Cheng SH, Dressman H, et al. Lancet. 10 May 2003. Vol.361. No.9369. p.1590-6.
Reviewed by Dr Tony Hanne
Review: Decisions about treatment of breast cancer have become much more complex in recent years but there is still huge uncertainty in predicting prognosis and therefore deciding how aggressive treatment should be. Currently there is heavy reliance on lymph node biopsy and whether oestrogen receptors are present. Gene patterns, known as metagenes, are shown in this study to be 90% accurate in predicting whether a woman is at high or low risk of recurrence. See also 23-272 for commentary.

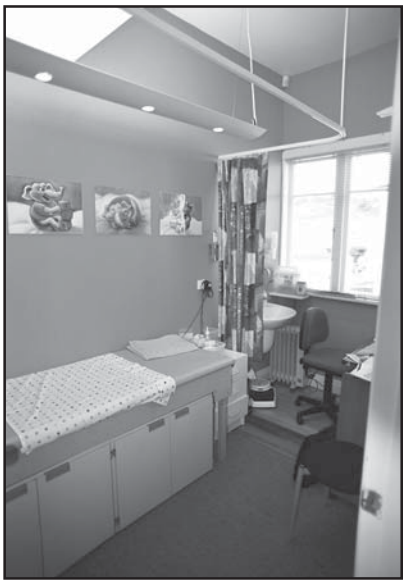

Photo: Michael Long

Comment: This is a glimpse of the future in which gene mapping will allow us to focus screening and intervention much more sharply on those at risk of many conditions. The article is highly technical and therefore not recommended bedtime reading, but the concept is worth getting hold of because we will hear about it more and more often.

23-272 DNA microarrays in breast cancer: the promise of personalised medicine.
Ramaswamy S, Perou CM. Lancet. 10 May 2003. Vol.361. No.9369. p.1576-7.
Reviewed by Dr Tony Hanne
Review: See 23-271.

Guidelines

23-273 How well do clinical practice guidelines guide clinical practice?
Gallagher EJ. Ann Emerg Med. October 2002. Vol.40. No.4. p.394-8.
Reviewed by Dr Mike Slatter
Review: This article examines the effect of clinical practice guidelines (CPG) almost 10 years since they were introduced. CPG have been un-

able to guide clinical practice to the extent originally hoped. Quality improvement, traditional CME, audit and feedback have not improved implementation of guidelines. What is proposed is that CPGs become embedded in Computerized Decision Support Systems (CDSS).
Comment: We really are an unchanging bunch but finally something to change our clinical habits. The CDSS, as a distillation of complex CPGs into actionable clinical reminders, should certainly keep us current and improve outcomes for our patients.

23-274 The relation between methods and recommendations in clinical practice guidelines for hypertension and hyperlipidemia.
Fretheim A, Williams JW, Oxman AD, et al. J Fam Pract. November 2002. Vol.51. No.11. p.963-8.
Reviewed by Dr Bruce Adlam
Review: This study looked at the association between the methods used to develop clinical practice guidelines and the recommendations that are made. Guideline developers who did not use rigorous methods appear to make more aggressive recommendations for screening and treatment (i.e. they were more likely to promote interventions).

Gynaecology

23-275 Premenstrual syndrome: Evidence-based treatment in family practice.
Douglas S. Can Fam Physician Med Fam Can. November 2002. Vol.48. p.1789-97.
Reviewed by Dr Mike Lyons
Review: Evaluates the evidence for various therapies currently used for PMS. Concludes there is good scientific evidence that calcium carbonate 1200 mgs/day and selective serotonin reuptake inhibitors are effective treatments. Inconclusive evidence for vitamin B6, evening primrose oil, oral contraceptives, aerobic exercise, stress reduction, cognitive therapy, spironolactone, magnesium, nonsteroidal anti-inflammatories, various hormonal regimes and complex carbohydrate-rich diet. Progesterone and Bromocriptine are also ineffective.
Comment: How long will we take to accept the evidence? Although 12 sites and 466 women were in the calcium trial, is recording of symptoms daily over three cycles adequate?

23-276 The Women's Health Initiative and HRT: Putting it all in perspective.
Ravnikar V. Patient Care. December 2002. Vol.36. No.14. p.53-75.
Reviewed by Dr Len Brake
Review: As the title suggests, this article is a summary of the controversy surrounding HRT and the WHI study that was needed due to adverse events. The facts are laid out in the form of a discussion between invited doctors. Although at times some of the replies are a little testy and defensive, it is an interesting and engaging way of updating the reader on HRT.
Comment: A recommended coffee read.

23-277 Postmenopausal hormone therapy in the aftermath of the WHI: What patients need to know.
Cyr MG. Postgrad Med. March 2003. Vol.113. No.3. p.15-20.
Reviewed by Dr Chris Milne
Review: Following the results of this study, hormonal therapy is now relegated primarily to the treatment of menopausal symptoms. It should be used in the lowest effective dose for the shortest duration possible. This represents a sea change from previous recommendations for its use in preventing chronic conditions (e.g. osteoporosis).
Comment: This article by an associate professor of medicine of Brown Medical School gives a useful American perspective on this important issue.

23-278 Infections of the female genital tract.
Nasraty S. Prim Care. March 2003. Vol.30. No.1. p.193-203.
Reviewed by Dr M Hewitt
Review: This looks at the STDs but also the other infective, come inflammatory, conditions involving the female genital tract.
Comment: The management strategies are particularly useful for those chronic recurring cases such as vaginitis.

23-279 Routine diagnostic hysteroscopy not necessary for premenopausal women with abnormal uterine bleeding.
Korsen N, Doyle L. J Fam Pract. November 2002. Vol.51. No.11. p.920.
Reviewed by Dr Bruce Adlam
Review: This small study suggests hysteroscopy is acceptable to patients and no more painful than endometrial biopsy. Routine hysteroscopy does not alter the rate of surgical intervention required by premenopausal women with abnormal uterine bleeding. (Original article reviewed: Br J Obstet Gynecol 2002; 109: 805-11)

Metabolic Diseases

23-280 Hemochromatosis: More common than you think.
Borgaonkar M. Can Fam Physician Med Fam Can. January 2003. Vol.49. p.36-43.
Reviewed by Dr Mike Lyons
Review: Outlines why this condition with a prevalence of one in 200 in some populations is under diagnosed – one study had a mean delay from symptom onset to diagnosis of 10 years. As the common presenting complaints are fatigue (54%), abdominal pain (48%) and palpitations (37%) and commonest findings are skin pigmentation (71%), Hepatomegaly (56%) and arthropathy (48%) the author suggests *'a diagnosis of HH should be suspected in any patient presenting with unexplained non-specific symptoms such as fa-*

tigue or arthralgia'! Clear table of diagnostic steps. Explains re transferrin saturation (measure of iron transport kinetics) and serum ferritin (marker of total body iron stores). Goes on to genotyping, limited place of liver biopsy, phlebotomy schedule and use of blood for donation in USA and Canada.
Comment: Useful overview article to add to the burgeoning literature on haemochromatosis.

Musculoskeletal System

23-281 Screening for osteoporosis in postmenopausal women: recommendations and rationale.

U.S. Preventive Services Task Force. Ann Intern Med. 17 September 2002. Vol.137. No.6. p.526-8.
Reviewed by Dr Mike Slatter
Review: The USPSTF recommends that women 65 years of age and older be screened routinely for osteoporosis. They also recommend routine screening from 60 years of age for women at increased risk of osteoporotic fractures. Low body weight (<70kgs) is the single best predictor of low bone mineral density. See also 23-282.

Photo: Michael Long

Comment: Bone density measurements do accurately predict the risk for fractures in the short-term and treating asymptomatic women with osteoporosis reduces their risk of fracture. The cost of bone density measurements may be an obstacle for many women.

23-282 Screening for postmenopausal osteoporosis: A review of the evidence for the US Preventive Services Task Force.

Nelson HD, Helfand M, Woolf SH, et al. Ann Intern Med. 17 September 2002. Vol.137. No.6. p.529-41.
Reviewed by Dr Mike Slatter
Review: See 23-281.

23-283 Claims for the anabolic effects of growth hormone: a case of the Emperor's new clothes?

Rennie MJ. Br J Sports Med. 1 April 2003. Vol.37. No.2. p.100-5.
Reviewed by Dr Chris Milne
Review: The author, who is a professor of molecular physiology, argues persuasively that growth hormone does not grow muscle in healthy adults. Athletes continue to abuse it, because it does retain salt and water, plus 'repartition' tissues, which reduces subcutaneous fat, and improves muscle definition. However, his main concern is that by ignoring the evidence that growth hormone does not work in normal healthy subjects, the anti-doping authorities may be promoting its use.
Comment: Thought provoking article about a controversial area. Because of its pulsatile secretion, designing an accurate test to detect growth hormone abuse has been very difficult.

23-284 Are ultrasound and magnetic resonance imaging of value in assessment of Achilles tendon disorders? A two year prospective study.

Khan KM, Forster BB, Robinson J, et al. Br J Sports Med. 1 April 2003. Vol.37. No.2. p.149-53.
Reviewed by Dr Chris Milne
Review: This two-year prospective study used ultrasound on 45 patients with 57 symptomatic achilles tendons, and 25 consecutive patients also underwent MRI examination. Both ultrasound (65%) and MRI (56%) demonstrated moderate sensitivity compared with clinical assessment. Graded MRI appearance was associated with clinical outcome, but ultrasound appearance was not.
Comment: This study, by world ranked researchers in tendon disorders, confirms that expert clinical assessment is still the main method of diagnosis for tendinopathy. Tendon imaging abnormalities persist even when patients have made a good functional recovery.

23-285 Advances in osteoporosis therapy: 2003 update of practical guidelines.

Khan A. Can Fam Physician Med Fam Can. April 2003. Vol.49. p.441-7.
Reviewed by Dr Mike Lyons
Review: This article in a symposium on osteoporosis (other articles waffle) *'reviews evidence for current therapies and establishes practical guidelines for management of osteoporosis'*. After brief recognition of secondary causes it updates evidence for therapy by biophosphonates, etidronate/alendronate and risedronate. Then covers raloxifene, calcitonin and HRT. Mentions parathyroid hormone as treatment of the future.
Comment: Won't help me manage my next 'fragile fracture' any better – especially since I could not see the promised 'practical guidelines'. Stick to your two-page medical information bulletin of February 2001 from the National Preferred Medicines Centre.

Neurology

23-286 Discovering the cause of syncope: A guide to the focused evaluation.

Hauer KE. Postgrad Med. January 2003. Vol.113. No.1. p.31-8.
Reviewed by Dr Chris Milne

Review: Vasovagal syncope is the most common type, and is usually triggered by pain, strong emotion, prolonged standing, or stress. Cardiac testing is indicated if cardiac disease is suspected on the basis of history or examination findings. The diagnostic yield of echocardiography is only five to 10%, and event recorders six to 31%. Tilt table testing is about 50% sensitive and 90% specific. In detecting seizures, a postictal state is the most helpful historical feature.
Comment: Useful refresher article for assisting doctors to evaluate a difficult symptom.

23-287 ß-Blockers no better than placebo in the treatment of vasovagal syncope.

Phillips J, Krist A. J Fam Pract. November 2002. Vol.51. No.11. p.921.
Reviewed by Dr Bruce Adlam

Review: This was a small unblinded crossover placebo controlled trial (30). Most patients had a profound response to ß-Blocker therapy over a three-month period. However, they had a similar response to placebo. (Original article reviewed: J Am Coll Cardiol 2002; 40: 499-504)
Comment: The author suggests that given we do not use placebos frequently then ß-Blockers if tolerated are an option.

Nutrition

23-288 A low-carbohydrate as compared with a low-fat diet in severe obesity.

Samaha FF, Iqbal N, Seshadri P, et al. N Engl J Med. 22 May 2003. Vol.348. No.21. p.2074-81.
Reviewed by Dr Raina Elley

Review: This study, and an accompanying study published in the same NEJM edition (see 23-289), are the first randomised trials designed to assess the effectiveness of the Low-Carbohydrate diet (Atkins diet). The comparison in both studies is a standard low-fat diet. In this study there were 132 participants, all with a BMI of over 35 (mean BMI of 42.9). Both groups were given dietary advice and left to follow the diet as would occur in real life. There were statistically significant greater reductions in weight after six months in the low-carbohydrate group compared with the low-fat group (-5.8 kg vs -1.9 kg, p=0.001). Other benefits were also observed such as reduced triglyceride levels and improved insulin sensitivity in the low-carbohydrate group compared with the low-fat group. The triglyceride and insulin resistance improvements were independent of weight loss. There were very high dropout rates, but lower dropout rates were observed in the low-carbohydrate diet group (33% vs 47%). As the study used an 'intention to treat' analysis, that meant that either baseline results or the most recent weight measure were used as the final measure for those who dropped out. Therefore, the greater adherence to the diet in the low-carbohydrate diet may have been partly responsible for the better outcomes. In addition, it seems that the greater weight-loss in the low-carbohydrate group was probably due to a greater reduction in overall caloric intake rather than an affect of the 'macronutrient' composition.
Comment: It may be that the low-carbohydrate diet is easier to comply with, or that the diet itself is more effective in short-term weight-loss. The effect on lipid profiles and glucose control and insulin resistance was not deleterious. In fact, there was some evidence of improvement. This surprised me, as a sceptic of the 'Atkins diet'. However, these results could have been biased by the lack of blinding and high and differential drop-out rates, which will always be a problem in this sort of trial. However, the objective outcome measures and the real-life setting (where there are likely to be high dropout rates anyway) make these results quite generalisable. Longer trials are needed with cardiovascular outcomes to ensure there is not a negative effect long-term from a diet that does not restrict fat or protein consumption, but limits carbohydrate.

23-289 A randomized trial of a low-carbohydrate diet for obesity.

Foster GD, Wyatt HR, Hill JO, et al. N Engl J Med. 22 May 2003. Vol.348. No.21. p.2082-90.
Reviewed by Dr Raina Elley

Review: This randomised trial is similar to the previous one (see 23-288), but was conducted with 63 obese men and women (mean BMIs of 33.9 and 34.4 in the two diet groups) over 12 months. Again, a low-carbohydrate diet was compared with a low-fat diet. The trial also shows greater weight-losses in the low-carbohydrate group compared with the low-fat group at three months (-6.8 vs -2.7 percent of body weight p=0.001) and six months (-7.0 vs -3.2 per cent of body weight, p=0.02). However, the differences are not significant at 12 months (-4.4 vs -2.5 percent of body weight). In addition, total cholesterol, particularly from LDL, is significantly lower in the low-fat group than the low-carbohydrate group at three months. The only lipid differences that remained significant at 12 months were reductions in triglycerides and increases in HDL concentrations in the low-carbohydrate group compared with the low-fat diet. However, a close look at the outcomes table shows a trend towards increased LDL in the low-carbohydrate diet group compared with the low-fat diet. This trend may have been more obvious had the sample size been larger, or the dropout rates lower.

Comment: Again the lack of blinding may have influenced results. There is also a substantial risk of the Hawthorn effect (with constant measurements by research staff, weight loss is probably more likely than in everyday life where no others are monitoring weight-loss). The concern that such low-carbohydrate and unlimited fat and protein diets may lead to increased cardiovascular risk is somewhat alleviated. However, a larger and longer trial would be reassuring that there is not a deleterious trend in LDL concentrations, or greater risk of cardiovascular event, with the low-carbohydrate diet, compared with a more conventional low-fat diet.

Occupational Health

23-290 Try before you buy.

Wilton A. Safeguard. May/June 2003. No.79. p.32-7.
Reviewed by Dr Michael Kahan
Review: A great review article covering *'why do pre-employment checks?'* and how to do them. The article provides a checklist of what needs to be covered. There is also a useful section written by a lawyer on issues to be aware of in relation to the Privacy Act, Human Rights Act and drug testing.
Comment: Very useful for any general practitioners involved in pre-employment checks and/or drug testing – beware there are many pitfalls.

Oncology

23-291 Screening for breast cancer: Recommendations and rationale.

U.S. Preventive Services Task Force. Ann Intern Med. 3 September 2002. Vol.137. No.5 Pt 1. p.E344-6.
Reviewed by Dr Mike Slatter
Review: This statement summarises the current US Prevention Services Task Force (USPSTF) recommendation for screening for breast cancer. The USPSTF recommends screening mammography with or without CBE (Clinical Breast Examination) every one to two years for woman aged 40 and over. There is insufficient evidence for or against recommending CBE or BSE. Recommendations of other North American groups are discussed.
Comment: Good resource to have when counselling woman re breast screening (especially 40–50 year olds). There are potential harms (false-positive results, unnecessary biopsies) and limitations of mammography that apply to women of different age ranges. (See also 23-292, 23-293 and 23-294)

23-292 Breast cancer screening: A summary of the evidence for the US Preventive Services Task Force.

Humphrey LL, Helfand M, Chan BK, et al. Ann Intern Med. 3 September 2002. Vol.137. No.5 Pt 1. p.E347-67.
Reviewed by Dr Mike Slatter
Review: See 23-291.

23-293 Screening mammography for younger women: back to basics.

Sox H. Ann Intern Med. 3 September 2002. Vol.137. No.5 Pt 1. p.361-2.
Reviewed by Dr Mike Slatter
Review: See 23-291.

23-294 The mamography dilemma: A crisis for evidence-based medicine?

Goodman SN. Ann Intern Med. 3 September 2002. Vol.137. No.5 Pt 1. p.363-5.
Reviewed by Dr Mike Slatter
Review: Editorial looking at the fact that evidence-based medicine has failed to produce a consensus on the benefits and harms of mammography. Different authorities cannot agree on which randomised, controlled trials (RTC) should be included in the evidence base. The author's opinion is that we need to navigate better within grey zones.
Comment: Concise assessment of the shortcomings of evidence-based medicine (EBM) and includes suggestions on how to cope better with uncertainty. (See also 23-291, 23-292 and 23-293)

23-295 Mammography service screening and mortality in breast cancer patients: 20-year follow-up before and after introduction of screening.

Tabar L, Yen M-F, Vitak B, et al. Lancet. 26 April 2003. Vol.361. No.9367. p.1405-10.
Reviewed by Dr Tony Hanne
Review: This Swedish study of over 200 000 women looked at the impact of mammography on mortality from breast cancer comparing 1958–77, before screening was introduced, with 1978–97. The study broke the results down according to age. The Swedish practice was to offer screening to all women from 40–69, those between 40–54 at 18 month intervals and the older women two-yearly. The results were clear. There was an overall reduction of 44% in mortality, about 18% of which was calculated to be due to better treatment and the rest to screening. The benefit in the 40–54 age group was just as great as in those who were older.
Comment: Much has changed over the past 20 years. Treatment is better and mammography has improved. Breast cancer rates in developed countries, however, continue to rise, presumably because of falling birth rates and higher abortion rates. NZ government unwillingness to fund screening of those in their 40s remains the same despite evidence like this.

Palliative Treatment

23-296 Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients.

McClain CS, Rosenfeld B, Breitbart W. Lancet. 10 May 2003. Vol.361. No.9369.

p.1603-7.
Reviewed by Dr Tony Hanne
Review: In a palliative care hospital, 160 patients with a life expectancy of less than three months were interviewed using standard questionnaires for depression, hopelessness and suicidal ideation. The levels of all three indicators were lower in those with a high sense of spiritual well-being. Even those who were clinically depressed were less likely to want to hasten death. The hospital was a Catholic one and 94% of the patients identified a religious affiliation of Catholic, Protestant or Jewish, although affiliation did not necessarily correspond with self reported spiritual well-being.
Comment: This study highlights the importance of encouraging and facilitating pastoral care in the terminally ill. It also gives some insight into what lies behind the growing demand for euthanasia.

Paediatrics

23-297 Risperidone improves behavior in children with autism.

Caicedo C, Williams SH. J Fam Pract. November 2002. Vol.51. No.11. p.915.
Reviewed by Dr Bruce Adlam
Review: Risperidone is an effective and relatively safe choice to decrease serious behaviour problems such as tantrum, aggression, and self-injury in children with autism. Side effects were expected and mild. No extra pyramidal symptoms were observed. (Original article reviewed: N Engl J Med 2002; 347: 314-21).

Primary Health Care

23-298 Incontinence Quality of Life Instrument in a survey of primary care patients.

Finkelstein MM, Skelly J, Kaczorowski J, et al. J Fam Pract. November 2002. Vol.51. No.11. p.952.
Reviewed by Dr Bruce Adlam
Review: Possibly a useful tool for all you chronic disease modelers out there. Correlates quite well with SF 12. SF 12 may have limited use in assessing quality of life in the Pacific Island population.

Psychiatry and Psychology

23-299 What to do if an initial antidepressant fails?

McIntyre RS, Muller A, Mancini DA, et al. Can Fam Physician Med Fam Can. April 2003. Vol.49. p.449-57.
Reviewed by Dr Mike Lyons
Review: Reviews diagnosis and initial treatment of depression mentioning pitfalls, differential diagnosis and psycho-education strategies to enhance adherence to treatment. Suggests strategies for dealing with relative (often wrongly labelled absolute) treatment-refractory depression. Outlines psychotherapy, augmentation, combining antidepressants, switching antidepressants and ECT.
Comment: Practical article that may increase confidence dealing with depressed patients. Complete with one page algorithm. Does not address increased suicide risk in teenagers with some SSRIs.

23-300 Clinical guidelines for depressive disorders: Summary of recommendations relevant to family physicians.

Kennedy SH, Lam RW, Morris B. Can Fam Physician Med Fam Can. April 2003. Vol.49. p.489-91.
Reviewed by Dr Mike Lyons
Review: Summary guidelines of a working party from Canada in 2001. Full text on website: www.canmat.org. Briefly covers definitions, diagnosis, prevalence, psychotherapy and drug therapy.
Comment: Despite all three authors' declared pharmaceutical competing interests this is a succinct revision article to initiate treatment. Ongoing management will need more depth.

23-301 Spirituality Index of Well-Being Scale: Development and testing of a new measure.

Daaleman TP, Frey BB, Wallace D, et al. J Fam Pract. November 2002. Vol.51. No.11. p.952.
Reviewed by Dr Bruce Adlam
Review: This scale proved to be valid and reliable method of subjective well-being in older populations living in Kansas City. It is less about 'religiosity' and more about 'self-efficacy' (i.e. 'I believe I can do it if I have too').
Comment: I admit to an initial 'only in America' response to this but on closer inspection it is quite an intriguing study, and, although most likely to throw up cultural variations, it would be a most interesting Masters project in the NZ setting.

23-302 New generation antipsychotics versus low-potency conventional antipsychotics: a systematic review and meta-analysis.

Leucht S, Wahlbeck K, Hamann J, et al. Lancet. 10 May 2003. Vol.361. No.9369. p.1581-9.
Reviewed by Dr Tony Hanne
Review: Thirty-one studies involving 2320 patients compared new generation antipsychotics with older medications looking at efficacy and the incidence of extra-pyramidal side-effects (EPS). The results were surprising. Only Clozapine has significantly less EPS. The efficacy of the newer agents was only moderately superior.
Comment: Only about one-third of the studies initially identified were suitable and of sufficiently high standard to be included which raises questions about the quality of evidence used to justify the immense expense of the newer drugs compared with earlier ones. The main older agent used for comparison was chlorpromazine. The risk of EPS with chlorpromazine was low if the daily dose was below 600mg.

Research Design and Methodology

23-303 Pharmaceutical industry sponsorship and research outcome and quality: systematic review.

Lexchin J, Bero LA, Djulbegovic B, et al. BMJ. 31 May 2003. Vol.326. No.7400. p.1167-70.

Reviewed by Dr Len Brake

Review: See 23-304.

23-304 Evidence b(i)ased medicine – selective reporting from studies sponsored by pharmaceutical industry: review of studies in new drug applications.

Melander H, Ahlqvist-Rastad J, Meijer G, et al. BMJ. 31 May 2003. Vol.326. No.7400. p.1171-3.

Reviewed by Dr Len Brake

Review: These two papers attempt to prove what is already known (see 23-303). That is that research funded by a particular drug company was more likely to have outcomes that favour that company's product. The studies show that it is not the quality of the methods used in the trials but the inappropriate comparators and publication bias that distorts the results.

Comment: The papers are interesting but surely there is not a single GP who takes a company funded trial at face value. American medical students are being asked to take a revised Hippocratic Oath that forbids the accepting of gifts, money, or hospitality from drug companies.

23-305 Intention-to-treat analysis: Who is in? Who is out?

Kruse RL, Alper BS, Reust C, et al. J Fam Pract. November 2002. Vol.51. No.11. p.969-71.

Reviewed by Dr Bruce Adlam

Review: There is considerable variation in how researchers define and apply the principle of 'intention to treat'. This study assessed whether the term 'intention to treat' predicts inclusion of all randomised subjects in the analysis. Studies have found that fewer than half of RCTs report intention to treat analysis and fewer than half of those that did actually analysed all randomised subjects (i.e. subjects were excluded for one reason or another such as 'received no follow-up', 'received no treatment', or were not found to meet the study entry criteria).

Respiratory System

23-306 Corticosteroid treatment for acute croup.

Rowe BH. Ann Emerg Med. September 2002. Vol.40. No.3. p.353-5.

Reviewed by Dr Mike Slatter

Review: This is an abstract of a systematic review from the Cochrane Database of Systematic Reviews and includes a comment by an Emergency Physician knowledgeable in this area.

Comment: Reinforces the needs to treat all but the mildest croup with corticosteroids (inhaled or systemic). There is no mention of the duration of treatment required.

Sexually Transmitted Diseases

23-307 US Centers for Disease Control and Prevention guidelines for the treatment of sexually transmitted diseases: An opportunity to unify clinical and public health practice.

Workowski KA, Levine WC, Wasserheit JN. Ann Intern Med. 20 August 2002. Vol.137. No.4. p.E255-61.

Reviewed by Dr Mike Slatter

Review: This paper examines new recommendations presented in the 2002 Centers for Disease Control and Prevention guidelines for the treatment of Sexually Transmitted Infections. New findings include: (1) Evaluation of chlamydial infection three to four months after primary infection. (2) Emergence of quinolone-resistant gonorrhea. (3) Commercial availability of type-specific serologic tests for genital herpes. (4) Screening and treatment for bacterial vaginosis before abortion or hysterectomy to reduce postoperative infectious complications. (5) Nucleic acid testing for human papillomavirus infection in the management of woman with Papanicolaou smears showing atypical squamous cells of undetermined significance.

Comment: Good update on the 'hidden epidemic'.

23-308 Sexually transmitted infections in men.

Kodner C. Prim Care. March 2003. Vol.30. No.1. p.173-91.

Reviewed by Dr M Hewitt

Review: Diagnosis and treatment of STDs are becoming more common in general practice. Keeping up-to-date with the latest diagnostic facilities and treatment regimens are discussed. Selective screening is mentioned for those men in high risk situations.

Comment: There is a trend for more men to seek treatment from their GP than to go to a specialist STD clinic. Funding remains an issue and GP's are obliged to keep up to date.

Sports and Sports Medicine

23-309 Are overground or treadmill runners more likely to sustain tibial stress fracture?

Milgrom C, Finestone A, Segev S, et al. Br J Sports Med. 1 April 2003. Vol.37. No.2. p.160-3.

Reviewed by Dr Chris Milne

Review: In vivo tibial strain measurements were conducted in three recreational athletes. Strain gauged staples were implanted surgically. Measurements were made running on a treadmill at 11 km per hour, and while outdoor running on asphalt at the same rate by a timed pacer. On the basis of lower in vivo strain rates recorded on the treadmill, the authors

suggest that treadmill runners are at lower risk of developing tibial stress fractures.

Comment: The study only involved three subjects, and subsequent larger studies would be needed before any definitive conclusions could be drawn.

23-310 Effect of wearing an ice cooling jacket on repeat sprint performance in warm/humid conditions.

Duffield R, Dawson B, Bishop D, et al. Br J Sports Med. 1 April 2003. Vol.37. No.2. p.164-9.

Reviewed by Dr Chris Milne

Review: Seven trained male hockey players performed 80 minute intermittent repeat sprint cycling exercise inside a climate chamber set at 30°C and 60% relative humidity. They were tested on two occasions a week apart, wearing an ice cooling jacket before and during recovery periods for one of the tests. Physical performance, was not improved, but the perception of thermal load was reduced.

Comment: Pre-cooling is an area of significant interest. This study proves that the players feel better when using cooling jackets. Physical performance was no different, but whether or not they would play better remains an open question.

23-311 Facilitating emotional intelligence in elite sport.

Gordon S. New Zealand Journal of Sports Medicine. Summer 2002. Vol.30. No.4. p.102-5.

Reviewed by Dr Rob Campbell

Review: This is a summary of a presentation given at the annual Sports Medicine and Science in NZ Conference. It looks at techniques to increase self-awareness, social awareness, self-management, and relationship management. All important in sports performance and life in general.

Comment: A useful introduction to the concepts and psychological techniques now used in elite sport.

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