Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Acta Obstet Gynecol Scand*
Am J Clin Nutr*
Ann Intern Med*
Aust Fam Physician*
BMJ*
Br J Sports Med*
Can Fam Physician Med Fam Can*
Clinical Acupuncture and Oriental Medicine
Dermatol Surg*
J Fam Pract *
J Intern Med*
J Tradit Chin Med*
J Voice*
JAMA*
Lancet*
N Engl J Med*
Postgrad Med*
*Journals Indexed in Medline

Acupuncture

24-247 Blinding in acupuncture research: a systematic review of randomized controlled trials for pain using a sham acupuncture control.

Trinh KV. Clinical Acupuncture and Oriental Medicine. 2003. Vol.4. No.2-3. p.71-7.
Reviewed by Dr Alex Chan

Review: The methods of delivering sham acupuncture for blinding in 19 studies were cited. Only three studies assessed the adequacy of the sham acupuncture, and no study attempted blinding of the treating acupuncturists. The author suggested that assessment of blinding is a critical aspect of any sham or placebo controlled trial and should be a routine part of the study.

Comment: The paper presented a good collection of sham acupuncture methods, but whether these were really inert measures have not been critically reviewed from a theoretical standpoint.

24-248 Acupuncture versus placebo versus sumatriptan for early treatment of migraine attacks: a randomized controlled trial.

Melchart D, Thormaehlen J, Hager S, et al. J Intern Med. February 2003. Vol.253. No.2. p.181-8.
Reviewed by Dr Alex Chan

Review: This study is a randomised controlled trial, which compared the effects of manual acupuncture, sumatriptan, or placebo injection in migranous patients who began to experience the premonitory symptoms of a migraine attack. The acupoints employed were GB-41, GB-20, GB-15, GB-14, GB-10, GB-8, LI-4, TW-5, GV-20, extra point Tai Yang and acupoints for associated symptoms. It was found that both acupuncture and sumatriptan were significantly more effective than a placebo injection in preventing the development of a full attack.

Comment: Note that adverse events including elevated blood pressure occurred in all three groups, though most frequently in the sumatriptan group. On the other hand, sumatriptan tended to give relief sooner than acupuncture, and was more effective when given a second time if a full attack developed.

24-249 Use of acupuncture for the treatment of adductor spasmodic dysphonia: A preliminary investigation.

Lee L, Daughton S, Scheer S, et al. J Voice. September 2003. Vol.17. No.3. p.411-24.
Reviewed by Dr Alex Chan

Review: A preliminary study on the effect of acupuncture on adductor spasm dysphonia for which repeated Botox injections is the only option up to now. Only 10 patients took part in this study. Acupuncture protocol involved the use of Lung (LU) and Large Intestine (LI) Distinct meridians, electrical stimulation, ear acupoints, body balance points and LI and Stomach (ST) Ting points over different points in eight weekly sessions. Extensive voice evaluation using standard tools and elaborative statistics showed significant changes in some but not all variables. However, seven of the 10 subjects reported improvement as perceived by themselves as well by their friends or relatives.
Comment: A good study but the acupuncture protocol itself contains too many variables which may hamper the overall body's response.

24–250 Botulinum toxin: application into acupuncture points for migraine.

Tamura BM, Chang B. Dermatol Surg. July 2003. Vol.29. No.7. p.749-54.
Reviewed by Dr Alex Chan
Review: Ten patients with intractable migraine were treated by injection with 37 units of Botulinum toxin into acupoints on the scalp, Trapezius, Temporalis and Semispinalis Capitis muscles. Intensity of pain was followed over six to eight months. All patients had maximal response from two weeks after application with pain scores reduction from 7-10 to 0-1. Effects started to wane after three months and slowly increased until the sixth month.
Comment: Injections of acupoints using herbs, saline or blood have been found in China to provide more lasting results than acupuncture or oral ingestion of herbs alone. The present study was carried out in a Brazilian University Dermatology Department. No placebo control was used because it was not allowed by the local Medical Ethics Commission.

24–251 Clinical application of point Diji.

Luan J. J Tradit Chin Med. June 2004. Vol.24. No.2. p.122-3.
Reviewed by Dr Joan Campbell
Review: Presentation of three clinical cases treated with Diji (SP 8) the xi-cleft point of the spleen channel of foot Taiyin.
Comment: Commonly used in obstetrics and gynaecology this point also has very useful applications for cardiac conditions, hypochondrial pain and disorders of stagnant qi and blood.

24–252 Topography of acupoint Jianjing (GB 21)

Cui H, Lou X, Jiang S, et al. J Tradit Chin Med. June 2004. Vol.24. No.2. p.138-9.
Reviewed by Dr Joan Campbell
Review: Twenty adult cadavers had a needle inserted into Jianjing (GB 21). A vertical dissection was made along the needle tract and the structures traversed by the needle were identified and the insertion depth and angle were also measured.
Comment: Jianjing (GB 21) is an important acupuncture point on the shoulder, located close to the apex and upper lobe of the lung. It is indicated for a wide range of musculoskeletal problems, obstetrical conditions, hypertension, depression etc. Traditionally the needle is inserted perpendicular. This paper recommends a depth of no more than 2.5cms and less than 1.5cms in the thinly built. Personally I needle the point across the trapezius muscle and this eliminates any risk of pneumothorax.

24–253 Problems with systematic reviews of acupuncture. What should we do about these?

Birch S. Clinical Acupuncture and Oriental Medicine. December 2003. Vol.4. No.4. p.105-8.
Reviewed by Dr Alex Chan
Review: This paper enumerated the problems with the methods used for systemic reviews of acupuncture in the past. It also provides solutions to the concerns raised. The issues discussed included the use of inclusion and exclusion criteria for the reviews, adequacy of treatments in the studies, inappropriate control needle treatments, and the validity of the 5-point Jadad scale in judging the quality of acupuncture trials. This is a follow-up to the author's discussion on the same topic as published in *Clinical Acupuncture and Oriental Medicine* 2001; 2(1): 17–22.
Comment: Systematic reviews of acupuncture studies may not be making the most appropriate conclusions be-

cause of limitations in methodology. On the other hand, future acupuncture studies need to be designed more vigorously. In particular, the common concern with placebo effects has to be addressed and accepted in a pragmatic way.

24–254 Laser acupuncture and low-calorie diet during visceral obesity therapy after menopause.

Wozniak P, Stachowiak G, Pieta-Dolinska A, et al. Acta Obstet Gynecol Scand. 2003. Vol.82. No.1. p.69-73.

Reviewed by Dr Alex Chan

Review: Seventy-four post-menopausal women with visceral obesity took part in a study comparing the effects of low calorie diet alone and low calorie diet supplemented with laser acupuncture on the reduction in body weight, body mass index and waist-to-hip ratio. The daily energy supplied was 1000 kcal below the calculated daily requirement in all participants. The special diet was given for a period of six months. Laser acupuncture was performed twice per week for six weeks. The laser beam has a frequency of 900Hz at 24mW with energy set at 0.1 J and applied for 10–15 seconds per point. The acupoints used were CV-12, ST-36, ST-25, LR-3, P6, H7 and Ear Shenmen and Stomach points. Both groups had a significant drop in body weight, body mass index and waist-to-hip ratio, but the mean reduction in the diet-plus-laser group was significantly higher than that of the diet alone group.

Comment: A practical clinical trial demonstrating extra benefits from the additional use of laser acupuncture. The study could have been more robust if 'placebo' lasers were used in a third group.

24–255 Cost effectiveness analysis of a randomised trial of acupuncture for chronic headache in primary care.

Wonderling D, Vickers AJ, Grieve R, et al. BMJ. 27 March 2004. Vol.328. No.7442. p.747 (5 pages)

Reviewed by Dr Alex Chan

Review: This study was performed at the same time as the study by Vickers et al. (see 24-256). The cost effectiveness of 'standard care' was compared to that of 'standard care plus acupuncture' in 401 patients with chronic headache. Total cost for the acupuncture group during the one year of study was higher on average because of the additional cost for acupuncture. However, the quality adjusted life year (QALY) gained was higher in the standard care plus acupuncture group in accordance with the observed reductions in headaches severity and frequency. The total gain would be higher if the prescription drug costs in the 'standard care' group and the productivity gain in 'standard care plus acupuncture' group were taken into consideration in the analysis.

Comment: This is the first vigorous economic evaluation of acupuncture available to date. An important article for policymakers and insurance companies.

24–256 Acupuncture for chronic headache in primary care: large, pragmatic, randomised trial.

Vickers AJ, Rees RW, Zollman CE, et al. BMJ. 27 March 2004. Vol.328. No.7442. p.744 (6 pages)

Reviewed by Dr Alex Chan

Review: Four hundred and one patients with chronic headache, predominantly migraine, took part in this study that compared the effects of 'standard care' from GPs plus acupuncture with 'standard care' from GPs alone. Fully concealed randomised minimisation was used to allocate patients to either group to minimise variables which might affect the results. Outcome measures included a daily headache diary and medication use, a SF-36 health status questionnaire for four weeks at baseline and then three months and one year after randomisation. Additional questionnaires monitored the use of medication and sick days from work. The acupuncture group had lower headache scores, fewer days of headaches, doctor visits and sick leave per year, and positive influences on physical role functioning, energy, change in health, and use of less medication.

Comment: Another practical clinical trials with robust design, large number of participants and relatively long follow-up. Trials such as this may impact on conclusions of future Cochrane reviews.

Alcohol and Substance Abuse

24–257 Psychological and social sequelae of cannabis and other illicit drug use by young people: a systematic review of longitudinal, general population studies.

Macleod J, Oakes R, Copello A, et al. Lancet. 15 May 2004. Vol.363. No.9421. p.1579-605.

Reviewed by Dr Tony Hanne

Review: This systematic review identified 48 relevant studies of which only 16 were found to be of high quality. There was fairly general agreement that cannabis use was associated with lower educational achievement, and increased use of other illicit drugs. Less certain was the evidence for psychological health problems and problematic behaviour. The reviewers point out how researchers so often fail to demonstrate what is cause and what is effect. For example, do those who are failing academically turn to cannabis for solace or has the cannabis caused their failure? Many of the effects of cannabis use are similar to those of tobacco and alcohol. If cannabis use really increases

Photo: Michael Long

schizophrenia four to fivefold why is it that in the past 30 years cannabis users have grown from 10% to 50% of young people while schizophrenia has remained unchanged or even fallen. Did prodromal signs of schizophrenia exist before cannabis started?

Comment: This analysis does not build a case for legalisation of cannabis but it does point to the hazards of citing poor evidence for political decisions. A delightful editorial in the same issue (see 24-258) describes the condition of CIPDS, cannabis-induced psychological distress syndrome, a widespread problem among politicians! What is demonstrated in this paper is how cannabis use is simply one part of a poor social environment and cannot be dealt with in isolation.

24-258 How to prevent cannabis-induced psychological distress...in politicians.

Grotenhermen F. Lancet. 15 May 2004. Vol.363. No.9421. p.1568-9.

Reviewed by Dr Tony Hanne

Review: See 24-257.

Alternative Medicine

24-259 General situation on the study of inspection of sublingual veins.

Chen Q, Xu Z, Chai Y. J Tradit Chin Med. June 2004. Vol.24. No.2. p.133-6.

Reviewed by Dr Joan Campbell

Review: The inspection of the sublingual veins is an integral part of tongue diagnosis. The sublingual veins connect directly with the zang-fu organs, qi and blood through the Channel system. Diagnostically the distension of the sublingual veins indicates blood stasis.

Comment: Useful diagnostic tool in diagnosing syndromes of blood stasis such as coronary artery disease, cerebrovascular disease, diabetes, etc.

Asthma

24-260 Are inhalers with spacers better than nebulizers for children with asthma?

Hsu JT, Parker S. J Fam Pract. January 2004. Vol.53. No.1. p.55-7.

Reviewed by Dr Bruce Adlam

Review: Metered-dose inhalers with a spacer are as good as, or better than, nebulisers for children with asthma. This is based on numerous randomised controlled trials that compared outcomes such as hospital admission rates, asthma severity scores, and pulmonary function scores (strength of recommendation: A).

Cardiovascular System

24-261 Is folate supplementation indicated for patients with CAD?

Hecox K, Hale W, Mackler L. J Fam Pract. January 2004. Vol.53. No.1. p.61-3.

Reviewed by Dr Bruce Adlam

Review: There is insufficient evidence to advocate the routine use of folate supplementation for the treatment of coronary artery disease (CAD). High levels of serum homocysteine have been associated in several studies with an increased risk for CAD (strength of recommendation B). Folate supplementation decreases the level of serum homocysteine (SOR: A).

Comment: This indirect evidence suggests that folate supplementation may be of benefit in slowing the progress of arteriosclerosis.

24-262 Candesartan reduces cardiovascular death in CHF patients on ACE inhibitor.

Wiley G, Cole C. J Fam Pract. February 2004. Vol.53. No.2. p.93-4.

Reviewed by Dr Bruce Adlam

Review: The addition of candesartan to an angiotensin-converting enzyme (ACE) inhibitor and other treatment reduces cardiovascular death and hospital admissions of patients with congestive heart failure (CHF). As in studies conducted with valsartan, candesartan added to an ACE inhibitor does not decrease overall mortality. Clinicians should add candesartan to the medical regimen in nonallergic CHF patients with an ejection fraction of 40% or lower who are already on an optimal dose of an ACE inhibitor. (Original article reviewed: Lancet 2003; 362: 767-71)

24-263 Does lowering diastolic BP to less than 90 mm Hg decrease cardiovascular risk?

Fontaine P, Nashelsky J. J Fam Pract. February 2004. Vol.53. No.2. p.144-6.

Reviewed by Dr Bruce Adlam

Review: Although lowering diastolic blood pressure (DBP) is associated with reduced cardiovascular events, systolic blood pressure (SBP) is a more robust predictor of cardiovascular risk than DBP and should now be used to diagnose, stage, and treat hypertension. Lowering diastolic blood pressure (DBP) to <90 mm Hg in hypertensive individuals of all ages decreases the

risk of cardiovascular events including myocardial infarction (MI), heart failure, and sudden death (strength of recommendation: A). However, there is no consensus regarding how far to lower DBP as an increase in cardiovascular risks may occur with DBP <85 mm Hg under certain conditions.

Comment: A 10-year observational study showed that in patients with a history of ischaemic heart disease, the incidence of fatal MI was lowest when DBP was between 85 to 90 mm Hg and increased with DBP <85 mm Hg, demonstrating a J-shaped curve.

24-264 Use of B-Type natriuretic peptide in the evaluation and management of acute dyspnea.

Mueller C, Scholer A, Laule-Kilian K, et al. N Engl J Med. 12 February 2004. Vol.350. No.7. p.647-54.

Reviewed by Dr Raina Elley

Review: Congestive heart failure (CHF) is the most common cause for hospitalisation for those over 65, and accounts for substantial secondary health care costs. It is often difficult to distinguish CHF from other causes of acute dyspnoea. Yet a definitive diagnosis is important for appropriate and cost-effective management. This randomised controlled trial (n=452) found that BMP as a diagnostic tool in the emergency department (in addition to 'usual care') was effective in reducing hospitalisations, intensive care treatment, length of hospital stay and costs of treatment for those presenting with dyspnoea, compared with 'usual care' alone. However, there was no significant difference in 30-day mortality. 'Usual care' included clinical history, examination, ECG, pulse oximetry, blood tests and CXR. Echocardiography and pulmonary function tests were often undertaken as an outpatient for those not admitted. BNP is 90% sensitive and 76% specific for CHF at a cut off of 100pg/ml.

Comment: This is a very encouraging finding. However, there are some cautions. Clinicians could not be blinded to allocation of intervention, as they needed to use the results of the BNP to make clinical decisions. This may have biased decisions about treatment and discharge. Even so, it is likely that the use of BNP as a diagnostic tool in general practice may also prove to be useful and cost-effective, particularly in helping to rule out CHF.

Cerebrovascular System

24-265 Antidepressant treatment reduces poststroke mortality.

Jorge RE, Robinson RG, Arndt S, et al. J Fam Pract. February 2004. Vol.53. No.2. p.96-7.

Reviewed by Dr Bruce Adlam

Review: Treatment with either fluoxetine or nortriptyline for 12 weeks during the first six months post-stroke reduced the mortality risk of both depressed and nondepressed patients. (Original article reviewed: Am J Psychiatry 2003; 160: 1823-9)

Comment: Strong consideration should be given to treating clinically depressed and nondepressed post-stroke patients who are at significant risk of developing depression (family history or personal history of mood disorders) with antidepressant medication.

Dermatology

24-266 Moving flash-fire cupping along the channels - a new method for treating urticaria.

Wang W. J Tradit Chin Med. June 2004. Vol.24. No.2. p.128.

Reviewed by Dr Joan Campbell

Review: A cup is flamed and adhered to the skin by the negative pressure formed inside the cup. Then the cup is moved up and down along the channels in the affected area of urticaria. Daily treatment is given for three days and usually one treatment is sufficient to cure acute urticaria.

Photo: Michael Long

Comment: The most common treatments for urticarial rashes in the Chinese model are herbal treatments and/or needles. Sliding cups along the bladder channel will abort the onset and development of wind cold (WM 8-colds, flu) and such a technique can be applied to affected channels in areas of urticaria, with good effect.

Diagnosis

24-267 Burning feet syndrome: a clinical review.

Makkar RP, Arora A, Monga A, et al. Aust Fam Physician. December 2003. Vol.32. No.12. p.1006-9.

Reviewed by Dr Barry Suckling

Review: Discusses the various aspects of this common and intriguing syndrome.

24-268 Failure to diagnose – fractures.

Bird S. Aust Fam Physician. March 2004. Vol.33. No.3. p.169-70.

Reviewed by Dr Barry Suckling

Review: Examines a claim involving a failure to diagnose a fracture, and outlines some of the risk management strategies for GPs to minimise the possibility of such a claim.

Ear, Nose and Throat

24-269 Influenza vaccine does not prevent acute otitis media in young children.

Jayatilake HP, Schwartz K. J Fam Pract. January 2004. Vol.53. No.1. p.17-8, 20.
Reviewed by Dr Bruce Adlam

Review: Practice recommendations – administration of influenza vaccine to children aged six to 24 months to prevent acute otitis media is not recommended. (Original article reviewed: JAMA 2003; 290:1608-1616)

Comment: There were no differences between vaccine and placebo groups in the monthly occurrence of acute otitis media episodes, the estimated proportion of days with middle-ear effusion, and use of selected health care and related resources.

Emergency Medicine

24-270 Drowning management and prevention.

Grenfell, R. Aust Fam Physician. December 2003. Vol.32. No.12. p.990-3.
Reviewed by Dr Barry Suckling

Review: Outlines the management of near drowning and the general practitioner's role in drowning prevention.

Endocrinology

24-271 Do ACE inhibitors prevent nephropathy in type 2 diabetes without proteinuria?

Sferra L, Kelsberg G, Dodson S. J Fam Pract. January 2004. Vol.53. No.1. p.68-9.
Reviewed by Dr Bruce Adlam

Review: ACE inhibitors make a significant difference for patients with diabetes as a whole. If patients both with and without microalbuminuria are included together, ACE inhibitors significantly reduce the progression of the albumin excretion rate and the development of overt nephropathy (both strength of recommendation A).

Comment: Results are contradictory regarding whether ACE inhibition delays new onset of diabetic microalbuminuria.

24-272 Type 2 diabetes: The role of basal insulin therapy.

LeRoith D, Levetan CS, Hirsch IB, et al. J Fam Pract. March 2004. Vol.53. No.3. p.215-22.
Reviewed by Dr Bruce Adlam

Review: Appropriate screening and earlier intervention may help reduce the incidence and progression of microvascular and macrovascular complications. A multifactorial approach that addresses such risk factors as blood pressure, lipids, and glycaemia has demonstrated reduced morbidity and mortality. Insulin combined with oral antidiabetic agents is too often considered a therapy of last resort.

Comment: These authors suggest this is an important intervention that can be used safely and effectively earlier in the course of type 2 diabetes.

24-273 Are ARBs or ACE inhibitors preferred for nephropathy in diabetes?

Foreman BH, Chambliss ML. J Fam Pract. March 2004. Vol.53. No.3. p.241-2.
Reviewed by Dr Bruce Adlam

Review: Angiotensin receptor blockers (ARBs) have been shown to reduce the progression of nephropathy in diabetes. While ACE inhibitors have not been as well studied for the endpoint of nephropathy, patients with nephropathy exhibit reduced mortality when treated with an ACE inhibitor (strength of recommendation: A).

Comment: The evidence is good that ARBs delay the progression of type 2 diabetic nephropathy. ARBs have not been shown to be as good as ACE inhibitors at reducing all-cause mortality, the most important patient-oriented outcome.

24-274 Recommendations from the Canadian Diabetes Association: 2003 guidelines for prevention and management of diabetes and related cardiovascular risk factors.

Harris SB, Lank CN. Can Fam Physician Med Fam Can. March 2004. Vol.50. p.425-9.
Reviewed by Dr Mike Lyons

Review: Succinct summary of the 2003 diabetes management guidelines. Tables management of hyperglycaemia, vascular, renal and blood pressure protection, lipid therapy in broad outline and hypertension treatment. ACE inhibitor and aspirin are priority management drugs.

Comment: Brief reminder of essential points. If you need to know in which patients the twofold increased risk of an upper GI bleed outweigh the benefit of aspirin on overall cardiovascular risk you will have to dig out your New Zealand December 2003 Guidelines – to save you reading all 143 pages you'll find the answer of page 50!

24-275 Treatment of hypertension in Type 2 diabetes mellitus: Blood pressure goals, choice of agents, and setting priorities in diabetes care.

Vijan S, Hayward RA. Ann Intern Med. 1 April 2003. Vol.138. No.7. p.593-602.
Reviewed by Dr Mike Slatter

Review: This Clinical Guidelines review article sets out to evaluate the goals and optimal agents for the treatment of hypertension in type 2 diabetes. Sixty per cent of type 2 diabetics will have hypertension and treating to BP goals of 135/80 mm Hg provides dramatic benefits. Thiazide diuretics, angiotension-2-receptor blockers and ACE inhibitors may be the best first line treatments. Aggressive BP control may be the most important factor in preventing adverse outcomes in type 2 diabetics.

Comment: Most adverse outcomes (80%) in diabetics are related to macrovascular events. Controlling macrovascular risk factors is as important as good glycaemic control. Most hypertensive diabetics will require more than one agent. (see also 24-276)

24-276 The evidence base for tight blood pressure control in the

management of Type 2 diabetes mellitus.

Snow V, Weiss KB, Mottur-Pilson C. Ann Intern Med. 1 April 2003. Vol.138. No.7. p.587-92.

Reviewed by Dr Mike Slatter

Review: See 24-275.

24-277 Systematic review and meta-analysis of randomised controlled trials of psychological interventions to improve glycaemic control in patients with type 2 diabetes.

Ismail K, Winkley K, Rabe-Hesketh S. Lancet. 15 May 2004. Vol.363. No.9421. p.1587-97.

Reviewed by Dr Tony Hanne

Review: Psychological intervention of various kinds was associated with a 1% improvement in HbA1c and a lowering of psychological distress but no change in random glucose or weight control. The writers acknowledge many limitations in their review. Intervention could not be blinded. Numbers in each of 25 trials they identified were small and research methods were often poor or only mediocre. They encourage this approach as an important addition to education, routine checks and pharmacological treatment to help stem the rising tide of diabetes. (see 24-278)

Comment: This exercise is a statistical triumph not a clinical one! The cost of this approach would be huge in terms of psychologists' time for a tiny gain in HbA1c. Only one study in 25 followed patients for longer than six months. Most of the treatments were in the form of group therapy where it is impossible to decide whether benefit comes from the therapist or the support of the group. Perhaps a coffee (but no cake!) group would have been just as effective, but more fun? We have got to do better than this.

24-278 Psychological, physiological, and drug interventions for type 2 diabetes.

Jenkins DJ. Lancet. 15 May 2004. Vol.363. No.9421. p.1569-70.

Reviewed by Dr Tony Hanne

Review: See 24-277.

24-279 Subclinical thyroid disease: Scientific review and guidelines for diagnosis and management.

Surks MI, Ortiz E, Daniels GH, et al. JAMA. 14 January 200. Vol.291. No.2. p.228-38.

Reviewed by Dr Raina Elley

Review: Subclinical hypothyroidism and hyperthyroidism are laboratory diagnoses made when serum T4 and T3 levels are normal but TSH is outside the statistically defined reference range. Excluding specific causes of these abnormalities, such as previous or treated thyroid disease or transient increases in TSH following serious illness, there is insufficient evidence that these laboratory abnormalities are associated with adverse cardiac or other clinical outcomes, apart from an association of sTSH >10mIU/L with raised total and LDL cholesterol. The prevalence of subclinical hypothyroidism is about 4% to 8.5% in the US (prevalence increases with age e.g. 20% of women over 60), yet only 2–5% per year of those with subclinical hypothyroidism progress to overt hypothyroidism. Subclinical hyperthyroidism is less common (2%) with few progressing to overt hyperthyroidism except if TSH is very low (<0.01mIU/L) of which only 1–2% per year progress to hyperthyroidism. There is insufficient evidence to demonstrate benefit from treatment of subclinical thyroid disease in most situations or population screening for these conditions. Even so, this article discusses the arguments for and against treating subclinical thyroid disease, particularly when TSH is markedly high or low (>10mIU/L or <0.01 IU/L), as well as the benefits suggested by small or poorer quality studies. The authors suggest clinical judgement and patient's preference should be considered when making a decision about screening and treatment. In addition, there is some evidence to suggest that subclinical hypothyroidism during pregnancy is associated with adverse outcomes of pregnancy so treatment is recommended. Screening TSH amongst women who are pregnant, or who are planning pregnancy, and are at risk of thyroid disease is also recommended.

Comment: This is a very comprehensive and systematic review of the evidence with practical recommendations. Considering how common this problem is in clinical practice, it is surprising there is such a paucity of good quality evidence about the therapeutic benefit of treating subclinical thyroid disease. This is an excellent article to gain a good perspective of the issues involved. (See 24-280)

Photo: Michael Long

24-280 Subclinical thyroid disease: clinical applications.

Col NF, Surks MI, Daniels GH. JAMA. 14 January 2004. Vol.291. No.2. p.239-43.

Reviewed by Dr Raina Elley

Review: This article uses the evidence from the previous article (see 24-279) to illustrate how to manage five different cases of subclinical thyroid dis-

ease. A useful algorithm for diagnosis and mangement is also presented.
Comment: Although the authors acknowledge that withholding treatment for slightly elevated or low TSH probably causes no harm and that giving treatment probably doesn't help, they do give examples where treatment may be justified after considering the clinical context of the problem or when TSH is more markedly abnormal.

Eye Diseases

24-281 Sudden onset double vision: Eye series – 11.

Hodge C, Martin F. Aust Fam Physician. December 2003. Vol.32. No.12. p.1016-7.
Reviewed by Dr Barry Suckling
Review: Good question and answer education on the sudden onset of double vision.

Family Practice

24-282 The decision to enter general practice.

Pearce C, Hegarty K. Aust Fam Physician. December 2003. Vol.32. No.12. p.1013-5.
Reviewed by Dr Barry Suckling
Review: The number applying to enter the GP Training Program in Australia is declining. There are unfilled places. The reasons are complex and these are discussed.
Comment: As one Canadian applicant put it: *'On one hand, being a family doctor who provides total care seems exciting. On the other hand, I am scared that I will be trapped in some isolated community, and buried under a mountain of office expenses and paperwork'.*

24-283 Home medicines Review: The how and why for GPs.

Emblen G, Miller E. Aust Fam Physician. January/February 2004. Vol.33. No.1/2. p.49-51.
Reviewed by Dr Barry Suckling
Review: The home medicines review was introduction in Australia in 2001 to help increase the appropriate use of medicines and reduce adverse events. It involves an accredited pharmacist in the assessment and education for patients' in the use of medications. On referral from a GP the pharmacist visits the patient's home to review total medication usage, and check the patient's use of medications against the GP's management plan.

24-284 How to write a medico-legal report.

Bird S. Aust Fam Physician. January/February 2004. Vol.33. No.1/2. p.66-7.
Reviewed by Dr Barry Suckling
Review: The aim of this article is to provide GPs with practical advice on how to write a medico-legal report and the pitfalls to avoid. Based on actual medical negligence claims.

24-285 The ultimate balancing act.

Young D. Aust Fam Physician. March 2004. Vol.33. No.3. p.101-2.
Reviewed by Dr Barry Suckling
Review: How to achieve balance in your life as an individual and as a GP.

Gastroenterology

24-286 Celiac disease: CME update for family physicians.

Devlin SM, Andrews CN, Beck PL. Can Fam Physician Med Fam Can. May 2004. Vol.50. p.719-25.
Reviewed by Dr Mike Lyons
Review: Good article covering the epidemiology, pathophysiology, screening and diagnosis, common presenting symptoms (and a few extra-GI red flags), disease associations, complications and treatment.
Comment: Useful article to read when confronted by a child with 'bad behaviour' and abdominal grumbles. Not as common here as when I worked in Belfast (1/150) but good to have an explanation of the reason why quantative IgA levels should be routinely ordered with celiac serology and why antigliadin antibodies should no longer be used for diagnosis.

24-287 Abnormal liver test results on routine screening: How to evaluate, when to refer for a biopsy.

Mallory MA, Lee SW, Kowdley KV. Postgrad Med. March 2004. Vol.115. No.3. p.53-66.
Reviewed by Dr Chris Milne
Review: GPs are often the first health care professionals to see LFT abnormalities that appear on screening. This article helps guide doctors through a potential minefield, and provides good advice re commonly seen test pattern abnormalities, and what to do about them. Important treatable conditions such as autoimmune hepatitis (seen in young to middle-aged women) and haemochromatosis may be identified first after abnormal LFT results.
Comment: Good practical article, of particular value to GP registrars who have not had that much exposure to gastroenterology.

General

24-288 What do Doctors find meaningful about their work?

Horowitz CR, Suchman AL, Branch WT. Ann Intern Med. 6 May 2003. Vol.138. No.9. p.772-5.
Reviewed by Dr Mike Slatter
Review: This article looks at what it is about the practice of medicine that is meaningful to doctors. The authors analyse accounts of work-related experiences that doctors found meaningful (was fulfilling and reaffirmed their commitment to medicine). Rather than tales of diagnostic and therapeutic triumphs the stories uniformly told about crossing from the world of biomedicine into their patient's world. Most stories took place in settings typically associated with

medical failure – death and progressive chronic illness.
Comment: The process of telling and exchanging can be valuable and personally renewing – it gives a clearer understanding of what nourishes and sustains us. The concept of 'narrative medicine' is discussed. A great read when you're feeling besieged and disillusioned with the business and bureaucracy of medicine.

Metabolic Diseases

24-289 When should we treat isolated high triglycerides?

Cucuzzella M, Smith PC, Nashelsky J. J Fam Pract. February 2004. Vol.53. No.2. p.142-4.
Reviewed by Dr Bruce Adlam
Review: No evidence exists that treating isolated high triglyceride levels in the absence of other risk factors prevents coronary events. Although elevated triglycerides in some studies correlates with coronary events, the association weakens when controlled for factors such as diabetes, high-density lipoprotein (HDL) and low-density lipoprotein (LDL) cholesterol, body mass index, and other cardiac risk factors.
Comment: Coincident lowering of triglycerides, while treating other dyslipidemias (such as high LDL and low HDL), can contribute to decreasing coronary events (strength of recommendation A).

24-290 Understanding hypercalcemia: Its metabolic basis, signs, and symptoms.

Inzucchi SE. Postgrad Med. April 2004. Vol.115. No.4. p.69-76.
Reviewed by Dr Chris Milne
Review: Hypercalcaemia is not that common in general practice. Hyperparathyroidism incidence is estimated at four cases per 100 000 people per year. Malignancy (particularly of the lung, breast or ovary) is the most common cause of non-PTH mediated hypercalcaemia. Thiazides, lithium, vitamin A or vitamin D can also raise serum calcium levels, as can prolonged immobilisation, especially in young people.
Comment: Useful update on an uncommon but challenging diagnostic problem.

Musculoskeletal System

24-291 What is the best treatment for Osgood-Schlatter disease?

Bloom OJ, Mackler L. J Fam Pract. February 2004. Vol.53. No.2. p.153, 56.
Reviewed by Dr Bruce Adlam
Review: Osgood-Schlatter disease is a common cause of pain and tenderness at the tibial tuberosity in active adolescents. It is typically a self-limited condition that often takes months to years to resolve entirely. It is best managed with conservative measures (activity modification, ice, anti-inflammatory agents) and time (strength of recommendation [SOR]: B). In chronic cases that are refractory to conservative treatment, surgical intervention yields good results, particularly for patients with bony or cartilaginous ossicles. Excision of these ossicles produces resolution of symptoms and return to activity in several weeks (SOR: C, several case series). Corticosteroid injections are not recommended (SOR: C, case reports and expert opinion).

24-292 Osteoporosis – diagnosis, treatment and management.

Phillips P, Braddon J. Aust Fam Physician. March 2004. Vol.33. No.3. p.111-9.
Reviewed by Dr Barry Suckling
Review: A practical case-based approach to assist in identifying and managing osteoporosis.

24-293 Patient education – the forgotten link in managing osteoporosis.

Laslett LL, McNeil JD, Lynch J. Aust Fam Physician. March 2004. Vol.33. No.3. p.121-4.
Reviewed by Dr Barry Suckling

Photo: Michael Long

Review: Guide for the GP through initial assessment and management of fractures, and a logical, simple structure for decision making.

24-294 Paget disease of bone: Diagnosis and indications for treatment.

Kotowicz MA. Aust Fam Physician. March 2004. Vol.33. No.3. p.127-31.
Reviewed by Dr Barry Suckling
Review: Outlines the clinical presentation, diagnosis and treatment of Paget disease.
Comment: A good review.

24-295 Shoulder stiffness: diagnosis.

Bhargav D, Murrell GA. Aust Fam Physician. March 2004. Vol.33. No.3. p.143-7.
Reviewed by Dr Barry Suckling
Review: Summarises the functional anatomy of the shoulder joint, the pathologies leading to the stiffness, and methods to differentiate them (see 24-296).

24-296 Shoulder stiffness: management.

Bhargav D, Murrell GA. Aust Fam Physician. March 2004. Vol.33. No.3. p.149-52.
Reviewed by Dr Barry Suckling

Review: Summarises the methods available to treat the various causes of stiff shoulder, identified in the previous 'diagnosis' article (see 24-295).

Neurology

24-297 Update on Parkinson Disease.

Siderowf A, Stern M. Ann Intern Med. 15 April 2003. Vol.138. No.8. p.651-8.
Reviewed by Dr Mike Slatter

Review: This update article reviews developments in the pathophysiology and treatment of Parkinson Disease. The current pathophysiological model emphasises abnormal protein aggregation. Good discussion regarding first line treatment – L-dopa versus Dopamine Agonist. The potential for surgical intervention is discussed.

Comment: Interesting aetiological link with caffeine intake (risk decreased with higher amounts of caffeine consumed) and pesticide rotenone. Three genes or genetic loci have been associated with Parkinson Disease. The search is on for 'neuro-protective' therapies to delay or arrest the premature neuronal loss in Parkinson Disease.

24-298 Effective treatment of migraine: Terminating acute attacks, reducing their frequency.

Pringsheim T, Edmeads J. Postgrad Med. April 2004. Vol.115. No.4. p.28-38, 50?
Reviewed by Dr Chris Milne

Review: This article describes general and specific treatment options for acute migraine attacks, and prophylaxis. It mentions the wide variety of triptans available in the USA, and concludes they are all of similar efficacy, but individual patients respond better to one agent than another. For prophylaxis, an adequate trial of at least eight to 12 weeks is needed, and remember that only 50% of patients respond well to the first migraine preventive drug they try. (see also 24-299 and 24-300)

Comment: Excellent article.

24-299 Is there an easy way to diagnose migraine? Challenges faced by primary care physicians include lack of time, training.

Edmeads J. Postgrad Med. April 2004. Vol.115. No.4. p.55-8.
Reviewed by Dr Chris Milne

Review: In short – no. The author came up with this mnemonic: A one-sided headache that pounds; and worsened by light and by sounds; likely is migraine; especially with bad pain; and throwing up over the ground. This isn't perfect, but it comes close! (see also 24-298 and 24-300)

Comment: The vast majority of patients with headaches intrusive enough to impair their abilities and take time out to see a doctor, probably have migraine. A few have something else, possibly something nasty. At present, there are no short cuts – it's plain old good history taking and sound clinical judgement, plus a trial of a specific anti-migraine preparation e.g. sumatriptan as a diagnostic/therapeutic initiative.

24-300 Migraine in special populations: Treatment strategies for children and adolescents, pregnant women, and the elderly.

Gladstone JP, Eross EJ, Dodick DW. Postgrad Med. April 2004. Vol.115. No.4. p.39-50.
Reviewed by Dr Chris Milne

Review: See 24-298 and 24-299.

24-301 Oral simvastatin treatment in relapsing-remitting multiple sclerosis.

Vollmer T, Key L, Durkalski V, et al. Lancet. 15 May 2004. Vol.363. No.9421. p.1607-8.
Reviewed by Dr Tony Hanne

Review: Thirty relapsing patients with MS were treated with simvastatin 80mg. The number of lesions seen on gadolinium-enhancing MRI scans before and up to six months after initiating treatment were compared. The number of lesions reduced 44% and the volume of lesions fell 41%. The rationale of treatment in the known anti-inflammatory effect of simvastatin is discussed. (see 24-302)

Comment: This is not a randomised control trial and therefore needs to be received with caution. Nevertheless this could be a real breakthrough in a tragic condition. The treatment was well tolerated. Most GPs would have one or two patients in this category whom we could safely begin to treat while we wait five years for a good RCT.

24-302 Statins for the treatment of multiple sclerosis: cautious hope.

Polman CH, Killestein J. Lancet. 15 May 2004. Vol.363. No.9421. p.1570.
Reviewed by Dr Tony Hanne

Review: See 24-301.

Nutrition

24-303 Phytoestrogens and breast cancer.

Ziegler RG. Am J Clin Nutr. February 2004. Vol.79. No.2. p.183-4.
Reviewed by Dr Charlotte Cox

Review: Phytooestrogens, which are widely distributed in plants, are structurally similar to mammalian oestrogens and can bind weakly to oestrogen receptors. The three major classes of phytooestrogens are isoflavones, which are concentrated in soybeans and soy products but also found in other legumes; lignans, which are distributed in seeds, whole grains, berries, fruit, vegetables, and nuts; and coumestans, which are found in broccoli and sprouts. Oestrogen is increasingly recognised as a cause of breast cancer. However, the role of phytooestrogens is ambiguous. For example in animal models and in vitro studies, phytooestrogens bind weakly to oestrogen receptors and can either produce or inhibit estrogen effects. The assumption that plant oestrogens are protective came from comparisons between international studies examining breast cancer rates and diet. Historically, breast cancer rates in the United States have been four to seven times those in Asia, whereas isoflavone intake in the United States is <1% that in Asian

populations. However, high soy consumption is only one of the many potentially protective lifestyle factors that distinguish Asian and Western women. Studies designed to compare phytoestrogen intake with the subsequent risk of breast cancer are difficult to undertake. Most studies to date are fraught with limitations. Limitations include the fact that food-composition data used to assess dietary intake is unable to keep up with newly identified plant phytooestrogens and phytooestrogen bioavailability differs from individual to individual due in part to variation in colonic metabolism. Hence, results from studies to date are complicated, inconsistent, and inconclusive. (see also 24-304)

Comment: Women, especially those at high risk, want to know whether phytooestrogens decrease or increase breast cancer risk. This editorial provides a nice summary of the role of phytooestrogens in breast cancer. We can tell our patients that scientific research does not support increasing phytooestrogen intake to Asian levels, nor does it suggest that the typical Western diet is problematic for healthy women.

24-304 Dietary phytoestrogens and breast cancer risk.

Keinan-Boker L, van der Schouw YT, Grobbee DE, et al. Am J Clin Nutr. February 2004. Vol.79. No.2. p.282-8.

Reviewed by Dr Charlotte Cox

Review: See 24-303.

24-305 Dietary supplements for body-weight reduction: a systematic review.

Pittler MH, Ernst E. Am J Clin Nutr. April 2004. Vol.79. No.4. p.529-36.

Reviewed by Dr Charlotte Cox

Review: This review article provides a useful summary of a systemic literature search of randomised clinical trials, systemic reviews, and meta-analyses of dietary supplements for body weight reduction. The preparations that met the appropriate inclusion criteria included: ayurvedic preparations; chitosan; chromium picolinate; ephedra sinica; garcinia cambogia; glucomannan; guar gum; hydroxymethylbutyrate; plantago psyllium; pyruvate; yerba mate and; yohimbe. These preparations are popular and can result in weight reduction, however, some can have serious adverse effects. For example, although ephedra sinica may promote a modest short-term weight reduction, it carries with it an increased risk of psychiatric, autonomic, or gastrointestinal symptoms and heart palpitations. Guar gum ingestion may potentiate the effects of insulin and decrease the absorption of oral contraceptives. Chromium picolinate has been linked with rhabdomyolysis and renal impairment.

Comment: Very worthwhile to have a summary at your fingertips of supplements that our patients are likely to be taking for weight reduction. The important take home message is that some of these supplements can result in weight reduction but the adverse effects shift the risk-benefit balance against their use.

24-306 Eating disorders in adolescence: An approach to diagnosis and management.

Cooke R, Sawyer SM. Aust Fam Physician. January/February 2004. Vol.33. No.1/2. p.27-31.

Reviewed by Dr Barry Suckling

Review: A review of eating disorders in adolescence, especially the role of the general practitioner in early recognition and management. Specific priorities in this age group are addressed.

24-307 Obesity in children: Tackling a growing problem.

McLennan J. Aust Fam Physician. January/February 2004. Vol.33. No.1/2. p.33-6.

Reviewed by Dr Barry Suckling

Review: A combination of dietary modification, increased physical activity, and behaviour modification is recommended.

24-308 Vitamin D in Australia: Issues and recommendations.

Nowson CA, Diamond TH, Pasco JA, et al. Aust Fam Physician. March 2004. Vol.33. No.3. p.133-8.

Reviewed by Dr Barry Suckling

Review: People at high risk of Vitamin D deficiency include the elderly, dark skinned people (particularly in pregnancy), and patients with malabsorption, e.g. celiac disease.

Comment: A good review of causes, consequences, treatment and prevention.

Occupational Health

24-309 Workplace expansion, long-term sickness absence, and hospital admission.

Westerlund H, Ferrie J, Hagberg J, et al. Lancet. 10 April 2004. Vol.363. No.9416. p.1193-7.

Reviewed by Dr Tony Hanne

Review: It has long been known that major downsizing in business whether private or public is associated with increased absenteeism due to sickness. This Swedish study demonstrates that substantial growth has similar effects on the workforce. The effect is greatest among the unskilled in all areas, and among women in the public sector. Moderate change whether up or down in an enterprise could if anything be associated with less absence.

Comment: Sweden has a stronger economy, a more stable workforce and higher levels of social welfare benefits than NZ, so one might assume the stresses of major restructuring, mergers and takeovers in this country would be even greater. As GPs we have a significant role as advocates for our patients who struggle to cope with Big Business or Big Government.

Oncology

24-310 Four-year prostate cancer screening interval is effective.

Schellhase KG. J Fam Pract. February 2004. Vol.53. No.2. p.101-2.
Reviewed by Dr Bruce Adlam
Review: This study found a relatively low rate of prostate cancer diagnoses during a four-year interval between screenings in Danish men aged 55 to 74 years. For those men choosing to undergo prostate cancer screening, these results show that annual screening is not necessary. Whether screening reduces prostate cancer-specific mortality is yet to be determined. (Original article reviewed: J Natl Cancer Inst 2003; 95: 1462-6).
Comment: Large study but with a few weaknesses which are discussed.

24–311 Three-year interval between Pap smears adequate for women with prior negative results.

Ohl M, Kane KY. J Fam Pract. March 2004. Vol.53. No.3. p.172, 75.
Reviewed by Dr Bruce Adlam
Review: This study predicts that among women aged 30 to 64 years with three recent, negative Pap smears, extending the interval for cervical cancer screening from one to three years would lead to an excess risk of cervical cancer of three in 100 000. (Original article reviewed: N Engl J Med 2003; 349: 1501-9)
Comment: For women aged 30 to 44 years, preventing one case of cervical cancer through yearly Pap smears would require an additional 69 665 Pap smears and 3861 colposcopies.

Orthopaedics

24–312 Early management of upper limb fractures in general practice.

Spain D. Aust Fam Physician. March 2004. Vol.33. No.3. p.105-9.
Reviewed by Dr Barry Suckling
Review: Guide for the GP through initial assessment and management of fractures, and a logical, simple structure for decision-making.

Prescribing

24–313 Monitoring: To infinity and beyond!

Shakib S, George A. Aust Fam Physician. December 2003. Vol.32. No.12. p.995-7.
Reviewed by Dr Barry Suckling
Review: Discusses the factors to consider when reviewing a patient for a repeat prescription and some approaches to long-term pharmacotherapy.

24–314 Medication errors – warfarin.

Bird S. Aust Fam Physician. December 2003. Vol.32. No.12. p.1003-4.
Reviewed by Dr Barry Suckling
Review: Medication errors are a common cause of medical negligence claims involving GPs. One of the medications frequently involved in these claims is warfarin.
Comment: Examines some of the medico-legal issues surrounding the initiation and monitoring of warfarin medication in general practice.

Preventive Medicine and Screening

24–315 Cardiorespiratory fitness in young adulthood and the development of cardiovascular disease risk factors.

Carnethon MR, Gidding SS, Nehgme R, et al. JAMA. 17 December 2003. Vol.290. No.23. p.3092-100.
Reviewed by Dr Raina Elley
Review: This 15-year longitudinal cohort study of 5000 healthy young adults enrolled at ages 18–30 years, found participants with the lowest fitness (<20th percentile) were three to six times as likely to develop diabetes, hypertension and metabolic syndrome compared with those with higher fitness (>60th percentile), after controlling for age, sex, race, smoking and family history. The association was still significant after controlling for BMI. Improving fitness over seven years was associated with reduced risk of diabetes and metabolic syndrome, although this association became less significant after controlling for change in weight.
Comment: We are reminded of the importance of physical fitness at a young age to ultimate cardiovascular outcomes. The other incidental finding in this study was that the leading causes of death in this age group during the study were AIDs (32%), homicide (17%), and unintentional injury (11%). (The study was conducted across four states in the US.)

Psychiatry and Psychology

24–316 Referral of patients with depression to specialist psychological care from general practice.

Blashki G, Hickie IB, Littlefield L, et al. Aust Fam Physician. December 2003. Vol.32. No.12. p.998-1002.
Reviewed by Dr Barry Suckling
Review: This is the fifth and final article in the series 'Psychological treatments in general practice'. It provides a practical four-step approach to assist general practitioners when referring patients suffering from depression.
Comment: Provides information and resources to help assessment, patient education, and long-term monitoring.

24–317 Childhood anxiety disorders: Approach to intervention.

Manassis, K. Can Fam Physician Med Fam Can. March 2004. Vol.50. p.379-84.
Reviewed by Dr Mike Lyons
Review: Helpful article by this Toronto psychiatrist from her experience and a Medline search. Outlines common worry symptoms, psychological interventions for anxious thoughts, common presenting behaviours and their therapeutic interventions and common presenting feelings and their attendant psychological management. Brief mention of SSRIs and updated caveat. Sensible suggestions re when to refer these chil-

dren. Principles used in dealing with a 10-year-old patient make the article GP orientated.
Comment: Recognises the place of the GP in treatment and gives confidence to deal with childhood anxieties. I liked the 'slow balloon breathing' for diaphragmatic breathing and the 'spaghetti legs' for muscle relaxation.

Research Design and Methodology

24–318 Remembering the meanings of sensitivity, specificity, and predictive values.

Rao G. J Fam Pract. January 2004. Vol.53. No.1. p.53.
Reviewed by Dr Bruce Adlam
Review: Sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) – collectively known as 'test characteristics' – are important ways to express the usefulness of diagnostic tests.
Comment: Good article.

24–319 Relative risks and odds ratios: What's the difference?

Last A, Wilson S, Rao G. J Fam Pract. February 2004. Vol.53. No.2. p.108.
Reviewed by Dr Bruce Adlam
Review: Some studies use relative risks (RRs) to describe results; others use odds ratios (ORs). Both are calculated from simple 2x2 tables. The question of which statistic to use is subtle but very important. RELATIVE RISK: Probability is the likelihood of an event in relation to all possible events. If a horse wins two out of every five races, its probability of winning is 2/5 (40%). Relative risk is a ratio of probabilities. It compares the incidence or risk of an event among those with a specific exposure with those who were not exposed (e.g. myocardial infarctions in those who smoke cigarettes compared with those who do not). RR is based upon the incidence of an event given that we already know the study participants' exposure status. It is only appropriate, therefore, to use RR for prospective cohort studies. ODDS RATIO: Odds compare events with nonevents. If a horse wins two out of every five races, its odds of winning are two to three (expressed as 2:3). An odds ratio is a ratio of ratios. It compares the presence to absence of an exposure given that we already know about a specific outcome (e.g. presence-to-absence ratio of cigarette smoking in those who had an MI compared with the same ratio in those who did not have an MI) (Figure). OR can be used to describe the results of case control as well as prospective cohort studies.
Comment: OR and RR are usually comparable in magnitude when the disease studied is rare (e.g. most cancers). However, an OR can overestimate and magnify risk, especially when the disease is more common (e.g. hypertension) and should be avoided in such cases if RR can be used.

24–320 Simplifying the language of evidence to improve patient care: Strength of Recommendation Taxonomy (SORT): A patient-centered approach to grading evidence in the medical literature.

Ebell MH, Siwek J, Weiss BD, et al. J Fam Pract. February 2004. Vol.53. No.2. p.111-20.
Reviewed by Dr Bruce Adlam
Review: SORT is built around the information mastery framework, which emphasises the use of patient-oriented outcomes that measure changes in morbidity or mortality. Several taxonomies exist for rating individual studies and the strength of recommendations, making the analysis of evidence confusing for practitioners.
Comment: This may not reduce the confusion a great deal. Although it has good intentions it is still another grading system combining A,B,C for level of recommendation with 1,2,3,4 levels of evidence.

24–321 The problem with Ps.

Rao G. J Fam Pract. March 2004. Vol.53. No.3. p.192.
Reviewed by Dr Bruce Adlam
Review: Most studies include a measure of the significance of treatment effects such as a P value or confidence interval (CI). CIs are usually preferred to P values, which have notable limitations.
Comment: P values are easily misinterpreted. A P value is the probability of obtaining a result (usually a difference between treatments) as large or larger than that observed in a study if the null hypothesis (i.e. no difference exists between treatments) is true. Differences in treatment effects can be expressed as absolute differences or as odds ratios. No difference, for example, corresponds to an absolute difference of zero or an odds ratio of 1.0. Consider a recent primary care study from the UK comparing the effectiveness of different lipid-lowering drugs to simvastatin. The odds ratio for achieving a cholesterol level of 5 mmol/L with pravastatin compared with simvastatin was 0.58, with a P value of .003 (i.e. simvastatin superior to pravastatin). This means that if there is no difference between pravastatin and simvastatin (ie. null hypothesis is true), the probability of getting an odds ratio of 0.58 or less is just .003 (0.3%).

24–322 Multivariable analysis: A primer for readers of medical research.

Katz MH. Ann Intern Med. 15 April 2003. Vol.138. No.8. p.644-50.
Reviewed by Dr Mike Slatter
Review: This review paper examines the basics of multivariable analysis including what multivariable models are, why they are used, what types exist, what assumptions underlie them and how they should be interpreted and evaluated.
Comment: A very complicated explanation which assumes some understanding of statistics. Important article for those involved in research and trials. I don't think it is possible to simplify these statistical concepts.

24–323 Practical clinical trials: Increasing the value of clinical research for decision making in clinical and health policy.

Tunis SR, Stryer DB, Clancy CM. JAMA. 24 September 2003. Vol.290. No.12. p.1624-32.
Reviewed by Dr Alex Chan

Review: The authors highlighted widespread inadequacy of available scientific evidence in the management of a number of clinical conditions. Examples given included the use of newer pharmacological agents for depression, newer broad-spectrum antibiotics for COPD, minimal invasive technologies for management of benign prostatic hypertrophies, and special beds for patients with pressure ulcers. To meet the needs of decision makers, practical clinical trials should be developed with hypothesis and design to specifically answer the questions for decision-making. These trials should select clinically relevant alternative interventions to compare, include a diverse population of study participants from different practice settings, and collect data from a broad range of health outcomes.

Comment: Future clinical acupuncture trials should be conducted along this line and the findings accepted as such. In the end, aren't we talking about POEMs nowadays?

Respiratory System

24-324 Geranium extract reduces bronchitis symptoms.

Gwynne M, Newton W. J Fam Pract. March 2004. Vol.53. No.3. p.180-1.
Reviewed by Dr Bruce Adlam

Review: This randomised, double-blind, placebo-controlled prospective study with concealed allocation study seems to provide good evidence that geranium root (Pelargonium sidoides) extract significantly reduces the severity and duration of acute bronchitis symptoms with minimal side effects (NNT=3). (Original article reviewed: Phytomedicine 2003; 10 (Suppl 4): S7-17)

Comment: Umcka, a geranium root extract, is marketed in the US. Note this report did not include children or pregnant women.

Rheumatic Diseases

24-325 How should we diagnose and treat osteoarthritis of the knee?

Holten KB. J Fam Pract. February 2004. Vol.53. No.2. p.134-6.
Reviewed by Dr Bruce Adlam

Review: When are x-ray films indicated for a patient with knee pain? When should we prescribe selective cyclo-oxygenase-2 (COX-2) inhibitors, instead of nonsteroidal anti-inflammatory drugs (NSAIDs)? How often can intraarticular steroids be used? What is the role of visco-supplementation? When is total knee replacement appropriate?

Comment: Answers to these and other questions can be found in a guideline from National Guideline Clearinghouse (www.ngc.gov).

Sports and Sports Medicine

24-326 Effects of leg massage on recovery from high intensity cycling exercise.

Robertson A, Watt JM, Galloway SD. Br J Sports Med. 1 April 2004. Vol.38. No.2. p.173-6.
Reviewed by Dr Chris Milne

Review: The effect of massage on recovery from high intensity exercise is debatable. In this small study of nine male games players, massage had no effect on blood lactate concentration or maximum power in a subsequent maximal spring (Wingate) test. However, the fatigue index was lower in the massage trial.

Comment: Massage is 'Mum and apple pie' therapy – no athlete is going to say it was of no benefit! This study adds to the body of literature which states that massage in recovery from exercise has no benefit on lactate clearance.

24-327 Is risk of fast bowling injury in cricketers greatest in those who bowl most? A cohort of young English fast bowlers.

Gregory PL, Batt ME, Wallace WA. Br J Sports Med. 1 Apr 2004. Vol.38. No.2. p.125-8.
Reviewed by Dr Chris Milne

Review: Fast bowlers suffer a high rate of injuries, particularly stress fractures of the low back. Cricket authorities have issued directives restricting the number of overs to be bowled (e.g. under 13: 2 spells of 3-4 overs, under 17: 3 spells of 4-5 overs). Some young bowlers exceed these directives. In this study, there was no significant increase in the injury rate amongst those bowlers who exceeded the directives.

Comment: This is a complex area, but maybe those bowlers had the most technically correct action, which tends to limit the risk of injury. The message remains clear – we need to nurture our young fast bowlers – national pride is at stake!

24-328 Child protection in sport.

Turner M, McCrory P. Br J Sports Med. 1 April 2004. Vol.38. No.2. p.106-7.
Reviewed by Dr Chris Milne

Review: Child abuse is a 'hot topic' at present. There have been several well documented cases of child sex allegations in a variety of sports. In addition, the excessive training loads of young gymnasts, swimmers and tennis players have received some attention. This article describes an initiative by the Lawn Tennis Association in Great Britain started in 1997.

Comment: This article provides a useful blueprint for all sports authorities. Doctors involved with junior sports programmes need to be vigilant at all times to the possibility of child abuse. The child who is chronically 'injured' and not wanting to play their chosen sport deserves our close attention.

Therapeutics

24-329 Do antipyretics prolong febrile illness?

Hudgings L, Kelsberg G, Safranek S. J Fam Pract. January 2004. Vol.53. No.1. p.57-58, 61.
Reviewed by Dr Bruce Adlam

Review: Antipyretics appear to have minor and variable effects on the course of febrile illness. Aspirin and acetaminophen do not prolong the course of rhinovirus illness, although they may prolong the period of viral shedding and worsen nasal congestion (strength of recommendation A-)
Comment: Study also looks at effects on chickenpox, shigella and malaria though in less robust studies.

Travel Medicine

24-330 Sexual health for travellers.

Hamlyn E, Dayan L. Aust Fam Physician. December 2003. Vol.32. No.12. p.981-4.
Reviewed by Dr Barry Suckling
Review: Discusses some of the STDs that may be acquired abroad, and suggests key points of pre-travel advice for the general practitioner to give to the traveller before their departure.

Urology

24-331 Approach to managing elevated creatinine.

Tremblay R. Can Fam Physician Med Fam Can. May 2004. Vol.50. p.735-40.
Reviewed by Dr Mike Lyons
Review: Standard, structured approach to interpreting elevated creatinine levels. History may help differentiate acute from chronic renal failure. Discusses prerenal, renal and postrenal causes. Outlines common causes in each category. Goes on to discuss Cockroft-Gault formula (now where is my blue freebie?), blood, urine and image testing. Brief history of a 59-year-old patient explains the approach.
Comment: May be a timely reminder for experienced GPs, or a useful reference article for tyros. Did you realise that the anaemia of chronic renal failure is absent in polycystic renal disease?

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