Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Am Fam Physician*
Aust Fam Physician*
BMJ*
Br J Sports Med*
Euro J Gastroenterol Hepatol*
JAMA*
Lancet*
N Engl J Med*
Palliative Med*
Pediatrics*
Prim Care*
Sci Am*
*Journals indexed in Medline

Acupuncture

26–265 Acute pancreatitis induced by traditional acupunture therapy

Uhm MS, Kim YS, Suh SC, et al. Euro J Gastroenterol Hepatol. June 2005. Vol.17. No.6. p.675-7.

Reviewed by Dr Alex Chan

Review: This is the first case report of acute pancreatitis as a complication of acupuncture. A patient who suffered from functional dyspepsia for one year and unresponsive to two months of H2-antagonist/prokinetics resolved to having acupuncture for her discomfort. She presented with severe abdominal pain five hours after 13cm long acupuncture needles were placed in three sites of the anterior abdominal wall. CT scan showed a swollen pancreas and pancreatitis was confirmed by blood tests. Other possible causes of pancreatitis such as alcohol use, biliary tract disease, infection, or medication were excluded. Patient recovered quickly with supportive treatment.

Comment: Just a reminder that patients do use alternative therapies and it is an advantage to have some knowledge of the complications of these therapies. Very long acupuncture needles are being used by traditionally trained acupuncturists in some areas of the world.

Asthma

26–266 Long-term inhaled corticosteroids in preschool children at high risk of asthma

Guilbert TW, Morgan WJ, Zeiger RS, et al. N Engl J Med. 11 May 2006. Vol.354. No.19. p.1985-97.

Reviewed by Dr Raina Elley

Review: This RCT showed that in two to three-year-olds with recurrent asthma symptoms, inhaled corticosteroids (fluticasone 176µg/d) reduce daily symptoms, slow growth by a small amount (1.1cm after two years), but do not reduce the long-term development of asthma symptoms after stopping the inhaled corticosteroid (i.e. no long-term protection is conferred). After one year of no inhaled corticosteroid height was still 0.7cm less than in the placebo group. (See also 26-267)

Comment: The persisting height discrepancy at this dose is a worry. Perhaps lower doses may have had similar control with fewer systemic effects.

26–267 Intermittent inhaled corticosteroids in infants with episodic wheezing

Bisgaard H, Hermansen MN, Loland L, et al. N Engl J Med. 11 May 2006. Vol.354. No.19. p.1998-2005.

Reviewed by Dr Raina Elley

Review: Inhaled corticosteroids (budesonide 400µg/day) produced no short-term benefit in infants (>1 month of age) with episodes of wheez-

ing and did not reduce the progression to persistent wheezing compared with placebo. The treatment was only initiated after three days of wheezing and was given by spacer for two weeks.
Comment: Lung function declines soon after developing asthma, so these authors hypothesised that treating infants in the 'pre-asthma' phase may prevent some of the loss in lung function. However, this trial and the trial reviewed above (see also 26-266) were unsuccessful in achieving this.

Cardiovascular System

26-268 Clinical assessment of limited value in DVT diagnosis

J Fam Pract. November 2005. Vol.54. No.11. p.394.
Reviewed by Dr Bruce Adlam
Review: Bottom Line: With the exception of either a previous deep venous thrombosis (DVT) or a previous malignancy, no other clinical feature effectively increases or decreases the odds of having a DVT. The Wells Clinical Prediction Score, which combines several clinical features, is much more effective. (LOE=1a) (Original article reviewed: Ann Intern Med 2005; 143:129-139)
Comment: For Wells Clinical Prediction Rule see 26-269.

26-269 Value of assessment of pretest probability of deep-vein thrombosis in clinical management

Wells PS, Anderson DR, Bormanis J et al. Lancet. 20/27 December 1997. Vol.350. No.9094. p.1795-8.
Reviewed by Dr Bruce Adlam
Review: Wells Clinical Predication Rule given in Table 1.
Comment: Risk score interpretation (probability of DVT): >=3 points: high risk (75%); 1 to 2 points: moderate risk (17%); <1 point: low risk (3%). See also 26-268.

26-270 Deceleration capacity of heart rate as a predictor of mortality after myocardial infarction: cohort study

Bauer A, Kantelhardt JW, Barthel P, et al. Lancet. 20 May 2006. Vol.367. No.9523. p.1674-81.
Reviewed by Dr Tony Hanne
Review: Implantable cardioverter defibrillators (ICDs) are being inserted for prevention of sudden death due to ventricular fibrillation after myocardial infarction. The problem has been to decide who would benefit from these devices. Currently the finding of low ventricular ejection fractions or of arrhythmias on Holter monitoring are used but the suspicion has persisted that these are often the wrong patients. This study tests the hypothesis that cardiac deceleration as part of sinus rhythm showing normal vagal function might be a better predictor of a good outcome. Some 2000 patients were followed after MI in three European centres. Failure of deceleration proved to be a much better predictor of sudden death. (See also 26-271)
Comment: The ICD has the potential to reduce sudden death after MI providing it is used in the right patient. Patients will be struggling to make informed choices about recommendations made to them by cardiologists for these expensive new toys. As GPs we need to understand the basis of sound advice.

26-271 Prediction versus prevention of sudden cardiac death

Viskin S. Lancet. 20 May 2006. Vol.367. No.9523. p.1639-41.
Reviewed by Dr Tony Hanne
Review: See also 26-270.

26-272 Nonpharmacologic strategies for managing hypertension

Wexler R, Aukerman G. Am Fam Physician. 1 June 2006. Vol.73. No.11. p.1953-6.
Reviewed by Dr Andrea Steinberg
Review: Lifestyle and dietary interventions are often overlooked in the management of hypertension. There are five modifications that have been proven to reduce blood pressure, although their direct impact on morbidity and mortality is not yet known. They are reducing sodium intake, increasing exercise, losing weight, dietary changes and moderating alcohol consumption. A diet rich in fruit and vegetables, high in low fat dairy products, potassium, magnesium and calcium and low in total saturated fats has been shown to produce reductions in blood pressure. This effect is increased if combined with reduction in sodium intake. Patient Information Attached.
Comment: There is no evidence for the effectiveness of alternative treatments such as vitamin C, Coenzyme Q10, and magnesium.

26-273 Three major statins have equivalent effectiveness

Shaughness AF. Am Fam Physician. 1 June 2006. Vol.73. No.11. p.2019.
Reviewed by Dr Andrea Steinberg
Review: These authors conducted a meta-analysis of all RCTs with at least 1000 participants that evaluated cardiovascular disease outcomes over at least one year. All studies showed a similar degree of reduction in lipid levels and there was no difference among the statins in reducing fatal coronary heart disease, non-fatal myocardial infarctions, fatal and non-fatal strokes, all cardiovascular deaths, or mortality from any cause. (Original Article Reviewed: Am Heart J 2006;151:273-81)
Comment: The overall effectiveness of statin therapy on the most important outcomes (mortality, MI and strokes) is not different among the three major statins.

26-274 Why is the mortality rate from acute MI higher in December?

Lin KW. Am Fam Physician. 15 April 2006. Vol.73. No.8. p.1454, 1456.
Reviewed by Dr Andrea Steinberg
Review: Why is the mortality rate for acute MI higher in December? This intriguing article discusses the fact that patients hospitilised for acute myocardial infarction in December have higher mortality rates than any other time of the year regardless of climate or geographic region. These authors tested whether the increased mortality in December was a result of less frequent use of evidence-

based therapies compared with other months. The study population consisted of 127 959 patients and statistical models controlled for potential confounding variables. The thirty day mortality rate for patients admitted with acute MI in December was significantly higher than for patients hospitalised at any other time of the year – 21.7 versus 20.1%. They found no statistically significant difference between the two groups in the provision of evidence-based therapies. (Original Article Reviewed: J Am Coll Cardiol 2005; 46:1473-8)

Comment: Were the patients upset because they missed Christmas at home, and the stress caused higher mortality? Clearly more studies are needed to determine a viable mechanism for this difference.

Communicable Diseases, Infections and Parasites

26–275 Pandemic influenza: how it would progress and what it would require of you

Campos-Outcalt D. J Fam Pract. December 2005. Vol.54. No.12. p.1045-8.

Reviewed by Dr Bruce Adlam

Review: An influenza pandemic, or world-wide outbreak, advances through three periods – inter-pandemic, pandemic alert, and pandemic – and their respective phases defined by the World Health Organization. This article describes the family physician's role in a pandemic and includes advice on diagnosis, treatment, and prevention of disease transmission. It is based on recent recommendations from US-CDC.

Comment: This article discusses what will be expected of primary care. It does not discuss how you protect yourself, your staff and family or in the absence of a publicised antiviral policy (if it's effective) – who gets it and for how long? Vaccine shortage is discussed, but with an estimated lag of 27 weeks for NZ to get its share, it is likely to be too little, too late.

26–276 What is the best treatment for pertussis?

Tubbs C, Niemi H, Mayo HG. J Fam Pract. December 2005. Vol.54. No.12. p.1096-8.

Reviewed by Dr Bruce Adlam

Review: Evidence based answer: A Cochrane review reveals a short-term course of erythromycin, azithromycin, or clarithromycin is as effective as a long-term (two-week) erythromycin therapy in eradicating Bordetella pertussis from the nasopharynx (SOR=A). Six randomised trials failed to show any statistically significant difference between antibiotics and placebo on frequency and severity of cough or duration of pertussis disease. Evidence is also insufficient to determine the benefit of antibiotic prophylaxis for pertussis contacts. There was no statistically significant difference in either the frequency of pertussis disease or rate of positive cultures in household contacts between households treated prophylactically with erythromycin (2.1%) and a placebo group (5.1%) However, due to high mortality and morbidity, prophylaxis is recommended for families who have an infant less than six months old (SOR = C; based on expert opinion).

Comment: Trimethoprim/sulfamethoxazole proved as effective as erythromycin in eliminating B pertussis from the nasopharynx.

26–277 Acellular pertussis vaccine 63% to 92% effective

J Fam Pract. January 2006. Vol.55. No.1. p.12.

Reviewed by Dr Bruce Adlam

Review: Clinical Question: Is the acellular pertussis vaccine safe and effective for adults and adolescents? An acellular pertussis vaccine reduces the risk of pertussis in adults and is well tolerated. (Level of evidence = 1b – RCT (double blind)) Adverse events were no more likely with the vaccine than with placebo. Vaccine efficacy was 63% to 90%. (Original article reviewed: N Engl J Med 2005; 353:1555-1563).

Comment: Using the strict case definition, in 2781 healthy adults, there were nine cases of pertussis in the control group and one in the vaccinated group (92% vaccine efficacy).

Contraception and Family Planning

26–278 Do antibiotics interfere with the efficacy of oral contraceptives?

Bauer KL, Wolf D. J Fam Pract. December 2005. Vol.54. No.12. p.1079-80.

Reviewed by Dr Bruce Adlam

Review: Evidence-based answer: Among antibiotics, only rifampin has been demonstrated to interfere with the effectiveness of oral contracep-

tives (OCs) (SOR: C based on a limited case series).There is little convincing evidence to show a systematic interaction between other antibiotics and oral contraceptive steroids (SOR: B). However, current studies may not have separately evaluated the minority of women whose metabolism of contraceptive steroids makes them more vulnerable to OC failure. Given the significant consequences of unintended pregnancy, some experts recommend a conservative approach, including patient education and backup forms of birth control.
Comment: An expert quoted in this article does not offer advice for short course antibiotics but does for longer term treatments (e.g. for acne).

Ear, Nose and Throat

26–279 Diagnosing Rhinitis: allergic vs nonallergic

Quillen DM, Feller DB. Am Fam Physician. 1 May 2006. Vol.73. No.9. p.1583-90.
Reviewed by Dr Andrea Steinberg
Review: A thorough history and a physical examination are necessary to differentiate between these two causes of rhinitis. Allergic rhinitis may be seasonal, perennial or occupational. Nonallergic rhinitis may be caused by acute viral infection or be vasomotor, hormonal, drug-induced, structural or occupational. It is important to differentiate between allergic and nonallergic as the latter do not respond to antihistamines or nasal corticosteroids. Skin tests may be useful.
Comment: An intimidating list of many causes of rhinitis which will not respond to the alanase which most GPs reach for by reflex. The trick is careful and detailed history taking.

Endocrinology

26–280 Home glucose monitoring makes little difference in type 2 diabetes

J Fam Pract. November 2005. Vol.54. No.11. p.936.
Reviewed by Dr Bruce Adlam
Review: Bottom Line: Intensive monitoring of blood glucose in patients with type 2 diabetes not using insulin results in a small decrease in glycosylated hemoglobin (Hb A1c) levels but does not change fasting blood glucose levels. Urine glucose monitoring works just as well. More casual monitoring of blood glucose, such as once a day, has not been studied. (Original article reviewed: Diabetes Care 2005; 28:1510-1517)
Comment: Interpret with some caution as study design is somewhat weak.

Evidence-Based Medicine

26–281 Remove the tooth, but don't stop the warfarin

Kamien M. Aust Fam Physician. April 2006. Vol.35. No.4. p.233-5.
Reviewed by Dr Mary Tucker
Review: This article compares common clinical practice with regard to cessation of warfarin before dental extraction with available evidence.
Comment: Best available evidence suggests that it is unwise to stop warfarin in patients prior to dental extraction if the INR is within the normal therapeutic range of 2–4. The result of a stroke is catastrophic whereas a bleeding tooth socket is merely messy and is usually readily controlled.

Eye Diseases

26–282 Age-related macular degeneration: options for earlier detection and improved treatment

Wiggins MN, Uwaydat SH. J Fam Pract. January 2006. Vol.55. No.1. p.22-7.
Reviewed by Dr Bruce Adlam
Review: A good article with good pictures diagrams and practice level recommendations. Key points: (1) Advanced age, positive family history, smoking, hypertension, and Caucasian ancestry are risk factors consistently associated with age-related macular degeneration (ARMD). (2) With older patients, suspect ARMD if vision has decreased or if grid testing reveals scotoma (C). Amsler grid testing can detect at a much earlier stage than can visual acuity testing alone. A Google search will bring up plenty of printable grids. (3) On fundus exam, dry ARMD shows drusen and changes in the retinal pigment epithelium; wet ARMD is a dark red or green spot on the macula. (4) Lifestyle modifications, vitamin supplementation for dry ARMD, and laser for wet ARMD can slow the effects of ARMD (A). The newest treatment which is showing promise for wet ARMD is pegaptanib (Macugen).
Comment: The vitamin dose referred to is: VITAMIN DOSE; Zinc 80mg; Vitamin C 500mg; Vitamin E 400IU; Beta-carotene 15mg; Copper 2mg.

Gastroenterology

26–283 Diagnostic challenges: differentiating nighttime GERD: issues for clinicians

Brunton S, McGuigan J. J Fam Pract. December 2005. Vol.54. No.Suppl. p.1073-8.
Reviewed by Dr Bruce Adlam
Review: Key points and recommendations: (a) Reflux episodes with night GORD occur less frequently but are

more prolonged than those with daytime GORD. (b) Oesophageal complications are generally more severe and more common in night time than in daytime GERD. (c) Night time GORD-induced alterations in sleep cause significant patient morbidity and reduced quality of life and productivity. (d) Factors are associated with night time GERD, including increased BMI, carbonated soft drink consumption, hypertension, benzodiazepine use, obstructive sleep apnoea, and asthma.
Comment: Rather wordy article to alert the reader to different symptomatology in GORD at night. Treatment is not discussed.

Gynaecology

26–284 What is the best way to diagnose menopause?

Kahwati LC, Haigler L, Rideout S. J Fam Pract. November 2005. Vol.54. No.11. p.1000-2.
Reviewed by Dr Bruce Adlam
Review: Evidence-based Review: No single test for menopause is highly sensitive and specific. The best predictors that a woman will enter menopause within four years include, age at least 50 years, amenorrhea for three to 11 months, and menstrual cycle irregularity within 12 months. For diagnosing perimenopause, the level of follicle-stimulating hormone (FSH) is most useful for clinical situations in which the pretest probability, as based on history, is midrange
Comment: In the reviewers' practice, they do not frequently use hormonal lab tests (FSH, luteinizing hormone, oestrogen), since they can be unreliable and do not usually affect clinical approach.

26–285 Amenorrhea: evaluation and treatment

Master-Hunter T, Heiman DL. Am Fam Physician. 15 April 2006. Vol.73. No.8. p.1374-86.
Reviewed by Dr Andrea Steinberg
Review: A comprehensive and detailed approach to the evaluation of a patient with amenorrhea; a common primary care presentation. The article presents an exhaustive list of the causes and an easily-followed algorithmic approach to diagnosis. Patient Information Attached.

Health Services

26–286 Shared decision-making not for all patients

J Fam Pract. December 2005. Vol.54. No.12. p.1028.
Reviewed by Dr Bruce Adlam
Review: Shared decision-making is not for all patients. In this cross sectional study of English speaking adults of 2750 survey respondents in the US, older, less educated people and those in poorer health prefer to rely more on their physician for information, rather than on their own knowledge, and would rather let their physician make health care decisions. Almost all people, however, want to know their options, even if they abdicate the decision-making. (Original article reviewed: J Gen Intern Med 2005; 20:531-535).
Comment: There are plenty of reasons why this might not be generalisable to the NZ population.

26–287 New York prepares to tackle homeless heath

Sharman CH. Lancet. 27 May 2006. Vol.367. No.9524. p.1719-20.
Reviewed by Dr Tony Hanne
Review: This World Report feature is a very thoughtful and sensible glimpse into the world of New York's 35 000 homeless people. They account for a disproportionate share of morbidity and mortality from substance abuse, HIV and mental illness. What is well demonstrated in this article is how necessary it is for doctors to engage with them as people before any serious attempt can be made to address their medical problems. Most have not trusted the system to help them for many years and need convincing that there are people who care. Other workers among the homeless argue strongly from their experience that the most effective starting point is to find them somewhere, however basic, which they can call home.
Comment: It is easy to blame New Zealand's homeless for their condition but so many are still victims of a society into which they do not fit. They have often made bad choices but we have been reluctant to provide them a way back in. While the scope of New Zealand's problems with homelessness is small compared with New York's, the lessons are much the same. Our health and social services are not as user-friendly as they need to be.

26–288 Quality of hospital care for Maori patients in New Zealand: retrospective cross-sectional assessment

Davis P, Lay-Yee R, Dyall L, et al. Lancet. 10 June 2006. Vol.367. No.9526. p.1920-5.
Reviewed by Dr Tony Hanne
Review: Some 6500 patients' hospital records were reviewed across New Zealand in public hospitals with more than 100 beds, searching for evidence of error which impacted on health outcomes. Over 11% suffered from significant events but when these were examined according to ethnicity, there was a 3% higher rate of error in Maori patients compared with non-Maori, non-Pacific. There were acknowledged differences between the two groups in that Maori patients were younger on average, included a greater proportion of maternity and neonatal problems and were more likely to be from deprived areas. The researchers were unable to identify any causes for the disparity.
Comment: The outcome of this study will be argued both ways. Some will see evidence of discrimination, others that the difference is small and that we are treating Maori fairly. Two areas seem worthy of further consideration. Eleven per cent overall is too

high and could be reduced by adopting the significant event analysis approach adapted from the airlines which looks to learn from error rather than blame. A much greater rate of error related to education in Maori patients and may reflect the far greater disparity which operates in schools.

Immunology and Allergy

26-289 Intrigue at the immune system

Davis DM. Sci Am. February 2006. Vol.294. No.2. p.48-55.
Reviewed by Dr Ron Vautier
Review: Microscopy reveals that the patches of membrane at which cells of the immune system come into contact with other cells and transfer signaling molecules, form definite structures which look rather like nerve cell synapses. The immune system is thereby revealed to be sophisticated information- sharing network.
Comment: Intriguing and beautifully illustrated (needs to be seen in colour).

Musculoskeletal System

26-290 Chronic compartment syndrome: tips on recognizing and treating

Englund J. J Fam Pract. November 2005. Vol.54. No.11. p.955-60.
Reviewed by Dr Bruce Adlam
Review: Practice recommendations: A patient's description of symptoms and pattern of occurrence is the most reliable clinical guide. Confirm suspicion of chronic compartment syndrome by documenting intracompartmental pressures. Other diagnostic modalities, though promising, have no place in the work-up currently.
Comment: Relatively useful study, which pragmatically acknowledges it is usually impractical to ask competitive athletes to change sports or reduce intensity. Fasciotomy is an effective treatment for chronic compartment syndrome and is preferred by some practitioners but levels of evidence backing recommendations are all low. Quite a good differential diagnosis is suggested.

Neurology

26-291 When is neuroimaging warranted for headache?

Grayson S, Neher J, Howard E. J Fam Pract. November 2005. Vol.54. No.11. p.988-9.
Reviewed by Dr Bruce Adlam
Review: Not a particularly useful article for primary care. Headaches of sudden onset occurring in patients with decreased levels of consciousness, focal neurological abnormalities and papilloedema are all pretty obvious alarm signals but it does not assist us in assessing what is to be done in patients with persistent severe headaches.

26-292 Practical strategy for detecting and relieving cluster headaches

Adams SM, Standridge JB. J Fam Pract. December 2005. Vol.54. No.12. p.1035-40.
Reviewed by Dr Bruce Adlam
Review: Practice recommendations:- (a) Learn to recognise the distinctive pattern of cluster headaches that in most cases, even if some symptoms suggest migraine, will readily reveal this disorder (SOR= C). (b) Give 100% oxygen by face mask and injected sumatriptan (Imitrex) are effective choices to terminate an acute attack (SOR=B). (c) Verapamil or corticosteroids abort cluster cycles and prevent further attacks (SOR= B).
Comment: Where intense pain is recurring at roughly the same time of day and lasting for about 45 minutes; the sufferer is unable to concentrate on anything but the pain and paces ceaselessly until it abates, the odds favour a diagnosis of cluster headache. Diagnosis is complicated in that 26% of sufferers also report a history of migraine. This is a useful, nicely written article which also explores alternative treatments.

26-293 Shutting down Alzheimer's

Wolfe MS. Sci Am. May 2006. Vol.294. No.5. p.72-9.
Reviewed by Dr Ron Vautier
Review: A promising strategy for treating Alzheimer's disease stems from the current understanding that it at least partly results from a build up in the brain of amyloid-beta. Thus research focuses on drugs which inhibit the enzymes involved in its production. Another approach is to stimulate the immune system to clear it away. The pathology also involves disrupted microtubules, with agents to inhibit this process also under investigation.
Comment: This article did a lot to advance my understanding of this increasingly common disease, and suggests optimism for its control in the foreseeable future.

26-294 Disorders of sleep: an overview

Ting L, Malhotra A. Prim Care. June 2005. Vol.32. No.2. p.305-18.
Reviewed by Dr M Hewitt
Review: As per title, with the authors looking at connections between disease states and their clinical manifestations in sleep disorders. A good understanding of the pathophysiological mechanisms involved greatly facilitates the diagnostic process.

26-295 Evaluation of the patient who has sleep complaints: a case-based method using the sleep process matrix

Rosen G. Prim Care. June 2005. Vol.32. No.2. p.319-28.
Reviewed by Dr M Hewitt
Review: History taking is the key but the author uses a template to assist evaluation. The template takes into account all the processes that affect, promote or provoke sleep complaints. Using this tool gives the history taker greater understanding and enables precision with diagnosis and management of sleep disorders.

26–296 Obstructive sleep apnea–hypopnea syndrome

Olson EJ, Park JG, Morgenthaler TI. Prim Care. June 2005. Vol.32. No.2. p.329-59.
Reviewed by Dr M Hewitt
Review: A good description and summary of the syndrome. Diagnostic criteria and up to date effective management are detailed.

26–297 Central sleep apnea

Badr MS. Prim Care. June 2005. Vol.32. No.2. p.361-74.
Reviewed by Dr M Hewitt
Review: A variation of obstructive sleep-apnea is described in greater detail. Diagnosis and principles of treatment remain familiar.

26–298 Insomnia

Neubauer D. Prim Care. June 2005. Vol.32. No.2. p.375-88.
Reviewed by Dr M Hewitt
Review: Historical collection of data is utilised to provide the probable diagnosis based on the presentation. The cause is often found in the history rather than the examination or special tests. The author discusses best management of these patients in primary care.

26–299 Narcolepsy and disorders of excessive somnolence

Dyken ME, Yamada T. Prim Care. June 2005. Vol.32. No.2. p.389-413.
Reviewed by Dr M Hewitt
Review: The authors describe in detail part of the original review by Jen Baptiste Gelineau in 1880. Using this description as a basis, they distinguish the syndrome from other sleep disorders and describe what is known about the condition and what is current best management.

26–300 Parasomnias and other sleep-related movement disorders

Lee-Chiong TL. Prim Care. June 2005. Vol.32. No.2. p.415-34.
Reviewed by Dr M Hewitt
Review: Not entirely as some might suspect a review of 'sleep walking' but rather description and discussion of movement and physical activity while in an altered state of 'non-consciousness'.
Comment: Lawyers love this stuff as a defence for all violent and inappropriate acts which are alleged to occur while one is in this state of 'non-arousal'.

26–301 Restless legs syndrome

Itin I, Comella CL. Prim Care. June 2005. Vol.32. No.2. p.435-48.
Reviewed by Dr M Hewitt
Review: These movements can occur while one is asleep but also when awake. The authors give a definition of the syndrome and make a distinction between the disorders involving sleep and when one is awake.
Comment: A little bit light on treatment which has been found to be effective. This is quite a common complaint in a primary care setting.

26–302 Circadian rhythm sleep disorders

Reid KJ, Burgess HJ. Prim Care. June 2005. Vol.32. No.2. p.449-73.
Reviewed by Dr M Hewitt
Review: The authors consider the effect of disturbance of circadian rhythm in modern life and discuss ways and means of ameliorating the adverse effects on individuals.
Comment: Light boxes and melatonin are now not just the preserve of alternative medical practitioners.

26–303 Sleep deprivation

Malik SW, Kaplan J. Prim Care. June 2005. Vol.32. No.2. p.475-90.
Reviewed by Dr M Hewitt
Review: The authors look at the effects of deprivation of sleep both in terms of adverse as well as positive results.
Comment: Mood elevation is common from sleep deprivation, but so is impaired performance.

26–304 Medications and their effects on sleep

Pagel JF. Prim Care. June 20005. Vol.32. No.2. p.491-509.
Reviewed by Dr M Hewitt
Review: The author looks in some depth at the side-effects of medicines which cause sleep disturbance as well as reviewing those which can be prescribed to ameliorate the situation.
Comment: We are talking about treatments, not cures. Diagnosis is still fundamental to the process of best management.

26–305 Sleep and medical disorders

Ballard RD. Prim Care. June 2005. Vol.32. No.2. p.511-33.
Reviewed by Dr M Hewitt
Review: The interaction between common pathological conditions such as hypertension, congestive heart failure, asthma, CORD, GORD and chronic kidney disease is described. The effect on sleep is a manifestation of the underlying disorder.
Comment: The author does not mention nocturia from prostatic hypertrophy or diabetes, but these two can easily be included in the above list.

26–306 Sleep in patients with neurologic and psychiatric disorders

Hoyt BD. Prim Care. June 2005. Vol.32. No.2. p.535-48.
Reviewed by Dr M Hewitt
Review: The author distinguishes in the presentation of sleep disorders between neurologic aetiology and psychiatric. Having made the distinction on the basis of the origin, then assessment and treatment success is based on the primary disorder and not the secondary manifestations.

26–307 Pediatric sleep disorders

Capp PK, Pearl PL, Lewin D. Prim Care. June 2005. Vol.32. No.2. p.549-62.
Reviewed by Dr M Hewitt
Review: Sleep disturbance in children is a very common reason for primary care visitation. Often the problem can be resolved with a diagnosis based on carefully taken history. The author considers that a greater awareness of different aetiologies of sleep disorders will result in superior management.
Comment: By far the commonest are of psycho-social origins in the early school age child up to adolescent.

Pre-school, a mixture of physical phenomena and psycho-social.

26-308 Sleep disorders in the older patients

Avidan AY. Prim Care. June 2005. Vol.32. No.2. p.563-86.
Reviewed by Dr M Hewitt
Review: Older people with sleep disorders are more easily diagnosed because of the likely aetiology related to age. Also the age-related changes to body symptoms, including the brain, provoke a variety of sleep disturbances.
Comment: Physical and neuro-degenerative causes predominate in older people. The natural decline of function of the recticular-activating system and its affect on sleep must always be a consideration when it comes to treatment and best management.

Nutrition

26-309 Austria plans gym discounts to help citizens get fit

Glenn J. Lancet. 13 May 2006. Vol.367. No.9522. p.1563.
Reviewed by Dr Tony Hanne
Review: This editorial describes Austria's attempts to combat its obesity related health problems by subsidising gym subscriptions. About one-third of Austrian adults and 15% of their children are overweight with lack of exercise being recognised as a key factor. The Austrian government believes that about $10 million spent in this way could save up to $10 billion in health costs! Surveys suggest that 86% of Austrians want to exercise but less than half actually do so regularly. Austrian public opinion is divided as to whether helping with gym costs will actually change behaviour. (See also 26-310)
Comment: It is a tragic irony that according to the WHO there are a billion people in the world who are overweight but at the same time another billion who are close to starving. Two lessons are worth noting from the Austrian example. Firstly there is a willingness to see that money spent by one government department could reflect in an improvement in the books of another department. Secondly unlike our Green Prescriptions the subsidy will be ongoing. Gyms acknowledge that most new members do not last beyond three months.

26-310 Curbing the obesity epidemic

Lancet. 13 May 2006. Vol.367. No.9522. p.1549.
Reviewed by Dr Tony Hanne
Review: See also 26-309.

26-311 Low-carbohydrate diets

Last AR, Wilson SA. Am Fam Physician. 1 June 2006. Vol.73. No.11. p.1943-8.
Reviewed by Dr Andrea Steinberg
Review: An overview of the currently fashionable low carb diet about which concerns have been raised due to the higher protein and fat content. Published long-term data are lacking. Short-term studies found improved lipid profile and HbA1C. These diets result in greater weight loss at three and six months than traditional diets, however, by one year there is no significant difference in maintained weight loss. There is a lower drop out rate with low carb diets possibly due to the appetite suppressant effects of the high protein content. See also 26-312. Patient Information Attached.
Comment: Weight loss is directly related to the ability to maintain caloric restriction, the nutrient proportions within that diet are irrelevant. None of the low carb diets discussed has been studied in a controlled trial longer than one year, and there has been no measurement of clinical outcomes such as cardiovascular events and mortality.

26-312 Low-carbohydrate dieting

Kirby RK. Am Fam Physician. 1 June 2006. Vol.73. No.11. p.1896.
Review: See also 26-311.

26-313 Nonalcoholic fatty liver disease

Bayard M, Holt J, Boroughs E. Am Fam Physician. 1 June 2006. Vol.73. No.11. p.1961-8.
Reviewed by Dr Andrea Steinberg
Review: This ubiquitous condition is the commonest cause of elevated liver enzymes in adults. It refers to a spectrum of diseases of the liver, ranging from benign steatosis, to significant cirrhosis. It is directly related to increasing body weight, and is associated with the metabolic syndrome. The diagnosis requires exclusion of alcoholic liver disease and viral hepatitis. Weight loss and exercise are recommended as first-line therapy. Treatment of associated insulin resistance and hyperlipidaemia may improve biochemical measures but there is no evidence that morbidity or mortality rates are improved with this therapy. Modest elevation of liver enzymes are not a contraindication to statin therapy if this is otherwise indicated. Progression to cirrhosis is rare. Patient Information Attached.
Comment: There are no data about the effects of treatment on mortality rates related to nonalcoholic fatty liver disease. Treatments have demonstrated improvements of liver enzyme levels, but there is no evidence as to positive effects on patient outcomes. In the meantime GPs should recommend weight loss, exercise and appropriate treatment for associated hyperlipidaemia and diabetes.

26-314 Effects of omega-3 fatty acids on cancer risk: a systematic review

MacLean CH, Newberry SJ, Mohica WA, et al. JAMA. 25 January 2006. Vol.295. No.4. p.403-15.
Reviewed by Dr Raina Elley
Review: Omega-3 Fatty Acids are not associated with decreased risk of cancer. The composite results from 38 articles (20 cohort studies examining 11 different cancers) were inconclusive. From the 65 estimates of association, only eight were statistically significant. Risk reductions were observed for breast, colorectal, lung and prostate cancer in some studies, but increased

risk was observed for breast, lung and prostate cancers in other studies. Most studies showed no association.

Comment: Omega-3 Fatty Acid dietary supplements should not claim reduction in cancer risk, as the overall evidence does not support this. An RCT would be the best way to determine a true association, although this would require a huge trial and the observational studies do not support the effort at this stage.

26–315 Calcium plus vitamin D supplementation and the risk of fractures

Jackson RD, LaCroix AZ, Gass M, et al. N Engl J Med. 16 February 2006. Vol.354. No.7. p.669-83.

Reviewed by Dr Raina Elley

Review: Calcium and vitamin D supplementation in healthy post-menopausal women increases bone density by a very small amount, but does not reduce, hip, vertebral or total fractures, according to a RCT of 36 282 women followed for a mean of seven years. There was also a significant increased risk of renal calculi in those taking the supplements, compared with placebo.

Comment: The lack of protection against fracture is consistent with other recent studies of healthy post-menopausal women living in the community (J. Porthouse, BMJ 2005). However, when the authors conducted a 'per protocol' analysis including only women who adhered to the protocol, there was a slight reduction in hip fracture compared with the placebo group. Therefore, with higher adherence rates or higher doses of Vitamin D (they used 400IU/day) or in a population that was Vitamin D deficient at baseline, there may have been a protective effect. (See 26-316.)

26–316 Calcium plus vitamin D for postmenopausal women: bone appetit?

Finkelstein JS. N Engl J Med. 16 February 2006. Vol.354. No.7. p.750-2.

Reviewed by Dr Raina Elley

Review: This editorial comments on Jackson's article reviewed above (see 26-315). The results from the literature are mixed, suggesting the protective effect of Vitamin D and calcium supplementation is probably group-specific. Apart from the poor adherence rates (only 59% were taking doses as recommended at the end of the study), Finkelstein points out that it would have been difficult to demonstrate a reduction in fractures in this study population because baseline Vit D levels were quite high, as were calcium supplements taken by participants at baseline. More than half of all were on HRT for at least some of the study, and they were also allowed to take extra Ca and Vit D supplementation, bisphosphonates or calcitonin during the trial. This would have added to the dilution of potential treatment effect.

Comment: Even so, there probably isn't enough evidence to routinely recommend calcium and vitamin D supplementation to healthy post-menopausal women unless there is a specific indication.

26–317 Calcium plus vitamin D supplementation and the risk of colorectal cancer

Wactawski-Wende J, Kotchen JM, Anderson GL, et al. N Engl J Med. 16 February 2006. Vol.354. No.7. p.684-96.

Reviewed by Dr Raina Elley

Review: Calcium and Vitamin D supplementation does not confer protection against colorectal cancer amongst post-menopausal women according to a RCT of 36 282 women followed for a mean of seven years. There was also no difference in the type or severity of the cancers found. It may be that any benefit would be evident after a longer follow-up, but no protective effect is yet evident. (See 26-318)

Comment: Despite an association of calcium and Vitamin D supplementation and reduced incidence of colorectal cancer found in observational studies previously, this RCT revealed no such protective effect.

26–318 Calcium plus vitamin D3 supplementation and colorectal cancer in women

Formann MR, Levin B. N Engl J Med. 354. Vol.7. No.7. p.752-4.

Reviewed by Dr Raina Elley

Review: This editorial comments on the article by Wactawski-Wende reviewed above (see 26-317). The authors point out that there is an estimated latency period of 10–20 years to detect reduction in colorectal cancer as a result of calcium and Vit D supplementation, and the women in the trial were younger than the age of high colorectal cancer incidence when the trial was stopped early (after seven years). Furthermore, because of the factorial design of the trial with HRT, dietary interventions and calcium/Vit D interventions, there was potential contamination of groups with other possibly effective interventions. Besides observational studies, animal studies have also indicated that calcium and Vit D reduce the incidence of colorectal cancer. Therefore, characteristics of the study design may have reduced the likelihood of finding a protective effect, and further investigation is warranted.

Obstetrics

26–319 Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment

Cohen LS, Altshuler LL, Harlow BL, et al. JAMA. 1 February 2006. Vol.295. No.5. p.499-507.

Reviewed by Dr Raina Elley

Review: Pregnancy does not protect against relapse of depression, as has been suggested previously. Maintaining anti-depressant medication throughout pregnancy of women with a previous history of depression, but who were euthymic at conception, was associated with a 26% relapse in depression during pregnancy while those who discontinued their antidepressant at conception or

just before had a 68% relapse rate. (Half of these relapsed in the first trimester and almost all by the end of the second trimester).
Comment: Although previous reports have not associated use of antidepressants in pregnancy with foetal abnormalities, recent reports have suggested there may be a slight increase in cardiovascular malformations associated with first trimester use of paroxetine (SSRI). However, it was not known whether discontinuing antidepressants in 'stable' women was associated with an increased risk of relapse during pregnancy. The researchers thought an RCT would be unethical, given current concerns, so followed a cohort of 201 pregnant women with a history of previous depression but who were euthymic for at least three months prior to pregnancy. Eighty-two chose to continue their antidepressant while the rest discontinued their antidepressant (just after or before conception). Women and their doctors need to weigh the risk of relapse of depression during pregnancy against possible (although unproven) risk of harm before discontinuing anti-depressants.

Oncology

26–320 GI malignancies in Australian general practice

Charles J, Miller G, Valenti L. Aust Fam Physician. April 2006. Vol.35. No.4. p.186-7.
Reviewed by Dr Mary Tucker
Review: This article provides a synopsis of the frequency and nature of consultations in Australian general practice related to GI malignancy
Comment: Setting the scene for the articles in the April issue of *Australian Family Physician* on the theme of GI malignancy.

26–321 Bowel cancer screening in Australia

Millard FB. Aust Fam Physician. April 2006. Vol.35. No.4. p.188-91.
Reviewed by Dr Mary Tucker
Review: Faecal Occult Blood screening for colorectal cancer has been shown, in international studies, to reduce the death rate from bowel cancer. Although Australia has one of the highest rates of bowel cancer in the world, only 40% of cases are detected early. This study surveys the acceptability, feasibility and cost-effectiveness of a home screening programme using the immunochemical Faecal Occult Blood Test (FOBT) in a pilot population in Australia. The test kit, which was delivered and returned by post, was user-friendly, low-cost and did not require dietary restriction.
Comment: This article makes a strong case for the use of FOBT screening for colorectal cancer in Australians aged 55–74 years, suggesting that it could be more cost-effective than current breast and cervical cancer screening programmes. Funding of general practitioners, who are pivotal to the success of a national screening programme, both by encouraging the uptake of screening and by referring of positive tests for colonoscopy, has not been a focus of planning. Workforce issues and cost may limit the availability of colonoscopy for follow-up of positive tests.

26–322 Bowel cancer –guide for the GP

Mc Murrick P, Dorien S, Shapio J. Aust Fam Physician. April 2006. Vol.35. No.4. p.192-7.
Reviewed by Dr Mary Tucker
Review: This article highlights the National Health and Medical Research Council guidelines for screening for colorectal cancer and discusses the application of these guidelines in selected cases. It discusses the variations in the mode of presentation of the disease, (many patients with advanced disease remain asymptomatic) and the importance of the referral for colonoscopy of any patient, over the age of 40 years, presenting with rectal bleeding. Preoperative work-up and counseling, primary treatment of colorectal neoplasia and treatment of recurrences are discussed.
Comment: A comprehensive review of the diagnosis of colorectal cancer, the relevance of screening, discussion of staging and the treatment of early and advanced disease, providing information that is relevant to general practitioners. Case studies focus on the management of the disease at various stages. Recent advances in therapy are discussed.

26–323 Diagnosis of upper gastrointestinal malignancy

Ryan J, Murkies A. Aust Fam Physician. April 2006. Vol.35. No.4. p.200-1.
Reviewed by Dr Mary Tucker
Review: Dyspepsia is a common complaint in clinical practice but upper GI malignancy is uncommon. In this article the 'alarm bells' that should trigger further investigation, (age >40yrs, dysphagia, early satiety, weight loss, anaemia, inadequate response to therapy with proton pump inhibitors or a palpable epigastric mass) and the management of patients without these 'alarm features' are discussed.
Comment: A summary of appropriate management illustrated by relevant cases.

26–324 Management of oesophageal carcinoma

Mackay S, Stefanou G. Aust Fam Physician. April 2006. Vol.35. No.4. p.202-6.
Reviewed by Dr Mary Tucker
Review: An overview of curative and palliative management options for oesophageal carcinoma. Surgery, endoscopic treatments, chemotherapy, radiotherapy and combined modality chemoradiation are considered.
Comment: An understanding of the available options will assist the general practitioner in supporting patients through all stages of decision-making in the progression of their disease.

26–325 Management of gastric cancer

Mackay S, Hayes T, Yeo A. Aust Fam Physician. April 2006. Vol.35. No.4. p.208-11.
Reviewed by Dr Mary Tucker

Review: An outline of the management options for patients with gastric cancer, a common cancer with a high mortality rate. Surgery remains the mainstay of treatment but a dedicated multidisciplinary team is important in the management of early gastric cancer. Palliation in advanced disease is explored.
Comment: The discussion of postoperative issues was relevant.

26–326 Pancreatic cancer: current management

Thomson BN, Banting SW, Gibbs P. Aust Fam Physician. April 2006. Vol.35. No.4. p.212-6.
Reviewed by Dr Mary Tucker
Review: The majority of patients diagnosed with pancreatic cancer present with advanced, inoperable disease. It is the fifth commonest cause of cancer-related deaths in Australia and, in the majority of cases, palliative care is all that can be offered. This article reviews available management options.
Comment: Pancreatic cancer remains a lethal disease and any improvements in care are likely to be in the field of palliation.

26–327 Life after breast cancer

Stuart K, Brennan M, French J, et al. Aust Fam Physician. April 2006. Vol.35. No.4. p.219-24.
Reviewed by Dr Mary Tucker
Review: This, the 13th article in a series on breast disease, explores the many issues that patients face after the completion of therapy for breast cancer. The importance of regular surveillance including physical examination and breast imaging and the value of scans and blood tests for investigation of symptoms is discussed. Other issues including the importance of nutrition and exercise, the management of lymphoedema, use of endocrine therapy, management of menopausal symptoms, breast reconstruction and psychosocial issues such as altered body image, changes in relationship with partner or children, living with any ongoing side effects and the fear of tumour recurrence and are explored.
Comment: A useful and relevant review of the many issues faced by breast cancer patients following therapy.

26–328 Lifestyle factors in the management of cancer

Hassed C. Aust Fam Physician. April 2006. Vol.35. No.4. p.242.
Reviewed by Dr Mary Tucker
Review: A review of two studies demonstrating the benefit of lifestyle changes in the management of cancer. (1): A prospective observational study of 2987 women with breast cancer, demonstrated the benefits of moderate physical activity in reducing recurrence of disease and prolonging survival. (2) A one year randomised controlled trial involving 93 patients with proven prostate cancer of watchful waiting compared with lifestyle and dietary changes, (group support, stress reduction, moderate exercise, a low-fat vegan diet with soy, selenium and fish oil supplements). Significant benefit was demonstrated in the lifestyle intervention group with overall fall in PSA, lack of disease progression and increased serum inhibition of growth of prostate cancer cells. The control group showed a significant increase in PSA and six men required treatment for disease progression.
Comment: How can we ignore the importance of lifestyle factors in the promotion of health and treatment of disease?

26–329 Osteoporosis from androgen deprivation therapy in prostate cancer treatment

McLeod N, Huynh CC, Rashid P. Aust Fam Physician. April 2006. Vol.35. No.4. p.243-5.
Reviewed by Dr Mary Tucker
Review: Osteoporosis, exacerbated by the use of ADT, reduces both the survival and quality of life of men who may otherwise live for many years with their well controlled prostate cancer. The importance of prevention and treatment of osteoporosis by addressing lifestyle factors, by calcium and vitamin D supplementation and use of bisphosphonates in this group of patients is highlighted.
Comment: A significant and increasing concern in a vulnerable, already osteoporotic group of patients. The article points out that 1/3 of Australian men over the age of 60 suffer from osteoporotic fractures with the number expected to double by 2026 and quadruple by 2061.

Palliative Treatment

26–330 Principles of control of cancer pain

Fallon M, Hanks G, Cherny N. BMJ. 29 April 2006. Vol.332. No.983. p.1022-4.
Reviewed by Dr Peter Woolford
Review: This is a very concise and excellent review of pain and pain control in cancer. I particularly like the figure that describes factors affecting patients perception of pain. This gives a basis on which to assess total pain, and points to other less commonly recognised remedial factors in pain.
Comment: Succinct, to the point. Excellent review for anyone working with cancer pain.

26–331 The sound of death rattle I: are relatives distressed by hearing this sound?

Wee BL, Coleman PG, Hiller R, et al. Palliative Med. May 2006. Vol.20. No.3. p.171-5.
Reviewed by Dr Peter Woolford
Review: Some are, some aren't, but by no means 100%. Some find it useful as a sign of impending death.
Comment: Would not bother getting a copy of the article but it is good to be aware of the issue. As we would expect – discuss with the family at the time.

26–332 Palliative care for patients with heart failure: description of a service

Johnson MJ, Houghton T. Palliative Med. May 2006. Vol.20. No.3. p.211-4.
Reviewed by Dr Peter Woolford

Review: There is increasing demand for heart failure patients to have access to palliative care services but there has been little improvement over the years in PC service. This is an attempt to improve the service offered.
Comment: This describes secondary intervention so is not directly applicable to us. However the principles of PC apply in the community and in the patients home as well, so often for us as GPs it is a matter of accepting that a patient is dying and moving with patient and family into a palliative mode. We are often better at recognising this transition than cardiologists.

26–333 Until the chemist opens: palliation from the doctor's bag

Seidel R, Sanderson C, Mitchell G, et al.
Aust Fam Physician. April 2006. Vol.35. No.4. p.225-30.
Reviewed by Dr Mary Tucker
Review: Palliative care is a valuable contribution to the welfare of patients with a life-limiting illness. General practitioners may need to deal with acute problems when they occur and also provide longer term care at home with the support of palliative care services in appropriate cases. The use of medications available in the doctor's bag for the relief of symptoms in these situations is explored.
Comment: A useful survey of readily available medications used in the symptomatic management of patients with life-limiting illness, along with evidence-based recommendations with regard to management strategies and medication dosage.

Paediatrics

26–334 Therapy with gastric acidity inhibitors increases the risk of acute gastroenteritis and community acquired pneumonia in children

Canani RB, Cirillo P, Roggero P, et al.
Pediatrics. May 2006. Vol.117. No.5. p.e817-20.
Reviewed by Dr Jocelyn Tracey
Review: This prospective study measured the incidence of acute gastroenteritis and pneumonia in babies aged four to 36 months in H2Blockers and PPIs and compared them with a control group. The incidence of gastroenteritis went from 18% to 43% and the incidence of pneumonia from 3% to 11% during the two months of medications compared to the four months before and four months after medication. There was no change in the control group.
Comment: This is something I was unaware of, but something parents need to know before we prescribe these medications.

26–335 A multi-center case-control study on predictive factors distinguishing childhood leukemia from juvenile rheumatoid arthritis

Jones OY, Spencer CH, Bowyer SL, et al.
Pediatrics. May 2006. Vol.117. No.5. p.e840-4.
Reviewed by Dr Jocelyn Tracey
Review: Acute lymphocytic leukaemia (ALL), the most common in childhood, may present with musculoskeletal pain before the blood film shows blast cells. In this study they reviewed the charts of 277 children referred to rheumatology clinics with musculoskeletal pain. The three useful predictive factors for distinguishing ALL were; musculoskeletal pain during the night, low white blood count, and low or low normal, platelet count.
Comment: I have included this review as a heads up for two conditions that are rare and may have slipped below our radar screens.

26–336 2005 American heart association (AHA) guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care (ECC) of pediatric and neonatal patients: pediatric basic life support

American Heat Association. Pediatrics. May 2006. Vol.117. No.5. p.e989-1004.
Reviewed by Dr Jocelyn Tracey
Review: These new guidelines have important changes to the existing ones in terms of resuscitation of children and neonates. The article summarises the changes and has some useful diagrams.
Comment: Those doing after hours call, PRIME, obstetrics and working in A&M centres should request a copy of this article.

26–337 Persistent cough and failure to thrive: a presentation of foreign body aspiration in a child with asthma

Kugelman A, Shaoul R, Goldsher M, et al.
Pediatrics. May 2006. Vol.117. No.5. p.e1057-60.
Reviewed by Dr Jocelyn Tracey
Review: This is a case report of a two-year-old child with asthma, lack of response to medications and failure to thrive. In this case it was thought that the initial CXR changes were due to bronchial plugging, but when there was no response to further treatment a bronchoscopy was performed and the peanut found!
Comment: A reminder to be alert for inhaled foreign bodies in children, and order a CXR if not responding to treatment.

26–338 The role of early maternal responsiveness in supporting school-aged cognitive development

for children who vary in birth status

Smith KE, Landry SH, Swank PR. Pediatrics. May 2006. Vol.117. No.5. p.1608-17.
Reviewed by Dr Jocelyn Tracey

Review: This article correlates parental patterns of responsiveness to their children with cognitive development from six months to 10 years. Even controlling for economic status there was a strong correlation between responsive interactive parenting and cognitive development, especially for very low birth weight babies.

Comment: This is particularly important for parents of very low birth weight babies to be aware of so we can encourage them in appropriate parenting styles.

26–339 Should pacifiers be recommended to prevent sudden infant death syndrome

Mitchell EA, Blair PS, L'Hoir MP. Pediatrics. May 2006. Vol.117. No.5. p.1755-8.
Reviewed by Dr Jocelyn Tracey

Review: An article from local paediatricians reviewing seven case control studies and one prospective study on whether the incidence of cot death is related to use of pacifiers. All show a reduced risk, pooled at an odds ratio of 0.48:1 for pacifier use.

Comment: This article goes as far as recommending that pacifier use not be discouraged. However, because of other studies that query an association between pacifier use and earlier cessation of breast-feeding, it stops short of positively promoting or recommending pacifier use.

26–340 Prescribing antibiotics does not save time

Shaughnessy AF. Am Fam Physician. 1 April 2006. Vol.73. No.7. p.1253.
Reviewed by Dr Andrea Steinberg

Review: In the study the authors evaluated the duration of visits for children presenting to primary care with colds or primary bronchitis. The mean duration of visits during which antibiotics were prescribed was 14.2 minutes and the mean time during which antibiotics were not prescribed was 14.18 minutes. Other studies have demonstrated that patient demand, patient satisfaction and the likelihood of switching doctors are not affected by the prescription of an antibiotic. (Original Article Reviewed: Arch Pediatr Adolesc Med 2005;159:1145-9)

Comment: Prescribing antibiotics for respiratory infections in children does not save time.

26–341 Swallowed coins: waiting equal to immediate removal

J Fam Pract. January 2006. Vol.55. No.1. p.16.
Reviewed by Dr Bruce Adlam

Review: Clinical Question: In asymptomatic children who present with

swallowed coins lodged in the oesophagus, is it better to remove them immediately or wait and remove coins still present 16 hours later? Despite waiting 16 hours for spontaneous passage, fewer than one in four (23%) oesophageal coins will do so. Conversely, 30% of children scheduled for removal will have passed the coin by the time they are prepped for surgery. (Original article reviewed: Pediatrics 2005; 116:614-9)

Comment: Based on this an eight to 16 hour period of observation is appropriate assuming that the child is asymptomatic, the ingestion was recent, and the child has no underlying oesophageal or tracheal abnormality. (Level of evidence =1b- RCT (non-blinded)).

Pharmacology

26–342 Pseudoephedrine has a minimal effect on blood pressure

J Fam Pract. January 2006. Vol.55. No.1. p.14.
Reviewed by Dr Bruce Adlam

Review: Clinical Question: Does pseudoephedrine increase blood pressure for normotensive persons or in those with hypertension? Immediate-release pseudoephedrine produces a small increase in systolic blood pressure (1.5 mm Hg) but has no effect on diastolic blood pressure. Sustained-release products do not affect blood pressure. Both types of products increase heart rate to a small degree. (Level of evidence = 1a – meta analysis of RCTs). (Original article reviewed: Arch Intern Med 2005; 165:1686-1694.)

Comment: The effect is dose related and a more marked effect could occur with overdose

Physician–Patient Relations

26–343 Diagnosis of chest cold may decrease antibiotic use

Slawson D. Am Fam Physician. 15 April 2006. Vol.73. No.8. p.1450.
Reviewed by Dr Andrea Steinberg

Review: These authors investigated the patient satisfaction with not receiving an antibiotic for acute respiratory illness in a descriptive study of 466 patients in an outpatient primary care setting. Three different diagnostic labels were used: chest cold, viral upper respiratory infection, and bronchitis. Those given the diagnostic label bronchitis reported significantly more dissatisfaction with not receiving an antibiotic (26%) as compared those given the diagnosis chest cold (13%) or viral upper respiratory infection (17%). (Original Article Reviewed: J Am Board Fam Pract 2005;18:459-63)

Comment: It's all in the spin!

Physiology

26–344 Unlocking the secrets of longevity genes

Sinclair DA, Guarente L. Sci Am. March 2006. Vol.294. No.3. p.48-57.

Reviewed by Dr Ron Vautier

Review: Sirtuins are a group of genes which control an organism's ability to withstand stress, and when activated over the long-term the response is to prolong life span. Resveratrol (as in red wine) modulates the activity of Sirtuins. Calorie restriction increases lifespan by acting as a stressor, not by slowing metabolism. Just a few other genes seem to be also relevant in reducing the effects of ageing.

Comment: A fascinating article from leading researchers in the field.

Preventive Medicine and Screening

26–345 How does colonoscopy compare with fecal occult blood testing as a screening tool for colon cancer?

Boggs BD, Stephens MM, Wallace R. J Fam Pract. November 2005. Vol.54. No.11. p.996-7.

Reviewed by Dr Bruce Adlam

Review: No studies have directly compared colonoscopy with faecal occult blood testing (FOBT). Multiple screening trials have demonstrated that a primary strategy of three-card home FOBT with follow-up colonoscopy for positive results is associated with significant reduction in mortality from colorectal cancer (strength of recommendation A). A single negative office-based digital FOBT does not decrease the likelihood of advanced neoplasia (SOR: B). There are no publications of screening trials with colonoscopy, but the odds of dying from colorectal cancer are lower for patients undergoing colonoscopy compared with patients not having a colonoscopy (SOR: B). Both strategies are cost-effective (SOR: A).

Comment: GPs need to find a systematic way to address colorectal cancer screening with their own patient populations, and find an effective way to determine whether their patients are at average or increased risk for colorectal cancer.

Psychiatry and Psychology

26–346 Newer antipsychotics similar to older agents

J Fam Pract. December 2005. Vol.54. No.12. p.1026.

Reviewed by Dr Bruce Adlam

Review: Newer antipsychotics are similar in effectiveness to older agents. There are few differences among newer antipsychotics and few differences between newer agents and perphenazine, an older agent. Olanzapine seems to offer somewhat greater effectiveness, but is less well tolerated and can produce some adverse changes to physiologic end points. All the newer antipsychotics are also much more expensive, which is a concern for this vulnerable group of patients. Based on its similar efficacy and better-than-expected tolerability this study recommends a typical phenothiazine should remain a treatment option for psychosis. (Original article reviewed: N Engl J Med 2005; 353:1209-1223).

Comment: Their recommendation here is for perphenazine which is similar to chlorpromazine but not available in NZ. (Level of evidence =1b)

26–347 How should we evaluate and treat ADHD in children and adolescents?

Ambalavanan G, Holten KB. J Fam Pract. December 2005. Vol.54. No.12. p.1058-9.

Reviewed by Dr Bruce Adlam

Review: This guideline update covers: (a) Who should be screened for ADHD? (b) Are laboratory studies helpful? (c) What are the most effective medications for treatment? And, (4) How effective is behaviour modification for treatment? These questions are answered in the graded recommendations derived from an evidence-based clinical practice guideline developed at Cincinnati Children's Hospital Medical Centre. The target populations are children between the ages of five and 18 years with symptoms of attention deficit/hyperactivity disorder (ADHD), excluding those with autism, mental retardation, or another mental disorder.

26–348 Maintenance treatment of major depression in old age

Reynolds CF, Dew MA, Pollock BG, et al. N Engl J Med. 16 March 2006. Vol.354. No.11. p.1130-8.

Reviewed by Dr Raina Elley

Review: Maintenance treatment with paroxetine for two years, even after a first episode of depression in the over 70-year-olds, significantly reduces the risk of recurrent depression compared with placebo. The addition of monthly psychotherapy made no difference.

Comment: Maintenance therapy with SSRIs after the usual six-month treatment for depression in older adults should be considered, especially as depression recurs within two to three years in 50–90% of cases in this age group. (The rate of recurrence was reduced to 35–37% with maintenance paroxetine).

26–349 Light therapy for SAD effective short-term

J Fam Pract. January 2006. Vol.55. No.1. p.15-6.

Reviewed by Dr Bruce Adlam

Review: Is light therapy effective for SAD? The available published research literature provides very weak evidence that light therapy is effective for seasonal affective disorder (SAD) or nonseasonal depression. Light therapy does not produce an additional effect when combined with pharmacologic therapy. Light boxes are expensive and may not provide the results desired by patients with SAD. (Level of evidence =1a systematic review.) (Original article reviewed: Am J Psychiatry 2005; 162:656-662.)

Respiratory System

26-350 Revisiting spirometry for the diagnosis of COPD

Holten KB. J Fam Pract. January 2006. Vol.55. No.1. p.51.
Reviewed by Dr Bruce Adlam
Review: Guideline update: Practice recommendations from Global Strategy for the management of chronic obstructive pulmonary disease (COPD) are: (1) The primary usefulness of spirometry is in identifying persons who will benefit from treatment to alleviate exacerbations (by confirming bronchodilator responsiveness). (2) Reserve spirometry for those with respiratory symptoms on effort (most beneficial in those with FEV1 50% or less of predicted value). (3) Spirometry is useful in diagnosing COPD when patients have suggestive symptoms. (4) Evidence does not support widespread use of spirometry to: (a) diagnose new cases of COPD in at-risk patients, (b) improve smoking cessation rates, (c) monitor the clinical course of COPD, or (d) adjust interventions.

Sports and Sports Medicine

26-351 The elbow: diagnosis and treatment of common injuries

Sellards R, Kuebrich C. Prim Care. March 2005. Vol.32. No.1. p.1-16.
Reviewed by Dr M Hewitt
Review: A comprehensive review of common injuries to the elbow and their sequalae, with known clinical syndromes. The anatomy of the elbow is also represented in relation to the injuries commonly sustained. (See also 26-352 and 26-353)
Comment: Excellent update.

26-352 The wrist: clinical anatomy and physical examination – an update

Eathorne SW. Prim Care. March 2005. Vol.32. No.1. p.17-34.
Reviewed by Dr M Hewitt
Review: A useful focus on the anatomy of the wrist and the relevant structures, biomechanics, and the physical examination. This allows for a uniform understanding for better communication from primary care physician to specialist. (See also 26-353 and 26-354)

26-353 The wrist: common injuries and management

Parmelee-Peters K, Eathorne SW. Prim Care. March 2005. Vol.32. No.1. p.35-70.
Reviewed by Dr M Hewitt
Review: A good review of the common injuries to the wrist; their history and mechanism of injury. Clinical features from presentation and examination are described. (See also 26-352 and 26-354)
Comment: In addition to assessment and treatment, best management options are discussed.

26-354 The hand in sports: an update on the clinical anatomy and physical examination

Patel D, Dean C, Baker RJ. Prim Care. March 2005. Vol.32. No.1. p.71-89.
Reviewed by Dr M Hewitt
Review: As per title. Augments the earlier review of the wrist; injuries, anatomy and biomechanics. (See also 26-352and 26-353).
Comment: Becoming more common, with more frequent exposure for the primary care physician, as well as the accident and medical care practitioner.

26-355 Hand injuries in sports medicine

Hong E. Prim Care. March 2005. Vol.32. No.1. p.91-103.
Reviewed by Dr M Hewitt
Review: The author presents a good overview with further detail of common injuries, their anatomy and treatment. Acute and chronic presentations are considered.

Urology

26-356 Assessment of microscopic hematuria in adults

McDonald MM, Swagerty D, Wetzel L. Am Fam Physician. 15 May 2006. Vol.73. No.10. p.1748-58.
Reviewed by Dr Andrea Steinberg
Review: Microscopic haematuria is often an incidental finding and needs to be thoroughly investigated as about 20% of patients have significant disease. Often the cause is not identified, especially in the younger patient. It is not recommended to screen asymptomatic patients, but this may be picked up incidentally by urine dipsticks and should be confirmed by microscopy. This article presents an algorithmic approach to the management of microscopic haematuria, which will eventually include IVP, ultrasound, cytology and cystoscopy. In addition this article presents a list of the many possible causes of this condition. Patient Information Attached.
Comment: A handy algorithm that is easy to follow when faced with a daunting list of possible causes.

26-357 Efficacy and safety of benzepril for advanced chronic renal insufficiency

Hou FF, Zhang X, Zhang GH, et al. N Engl J Med. 12 January 2006. Vol.354. No.2. p.131-40.
Reviewed by Dr Raina Elley
Review: Angiotensin converting enzyme (ACE) inhibitors reduce proteinuria and slow the decline in renal function by 23% in those with advanced renal insufficiency (sCr 274-442 µmol/l or GFR 15-29 ml/min) independent of blood pressure reduction. These findings were from a RCT of 224 patients without diabetes followed for a mean of 3.4 years. Blood pressure was titrated to below 130/80 by adding other anti-hypertensive agents to all participants. There were no significant increases in major adverse events. There were six reported cases of hyperkalaemia but this was not significantly different from in the placebo group. There was an extra comparison group with mild renal insufficiently to ensure side effects were not greater in those with advanced renal sufficiency taking Benazepril.

Comment: We know ACE inhibitors are reno-protective in mild renal insufficiency and in diabetes. However, because of the perceived risk of hyperkalaemia and worsening of serum creatinine, ACE inhibitors are sometimes avoided in those with advanced renal insufficiency without diabetes. This trial shows that they are both relatively safe and reno-protective in this group also, independent of blood pressure reduction. (See 26-358.)

26-358 Optimizing ACE-inhibitor therapy for chronic kidney disease

Herbert LA. N Engl J Med. 12 January 2006. Vol.354. No.2. p.189-91.

Reviewed by Dr Raina Elley

Review: This editorial comments on Hou's article, reviewed above (see 26-357). Hou et al. showed that Benazepril at half maximal doses (20mg/d) was reno-protective without major side effects in those with advanced renal insufficiency (stage 4 chronic renal disease). Herbert suggests the low rate of hyperkalaemia may have been because during the eight week run-in period the 5% who developed hyperkalaemia or increased serum creatinine were excluded from the study. Also, the Chinese population of the trial have a lower K+ content in their diet, and because 80% were also receiving a diuretic, which would have countered a rise in potassium.

Comment: These factors should be considered (such as K+ dietary intake) before translating this evidence into practice in other settings. Herbert also discusses other possible approaches, such as adding an angiotensin-receptor blocker to an ACE inhibitor, which has been shown to reduce renal decline in those with stage 3 renal disease. Also, there is some evidence to suggest that adding a statin to an ACE inhibitor may reduce proteinuria and renal decline further, while the addition of a dihydropyridine Ca channel blocker to an ACE inhibitor for blood pressure reduction does not decrease proteinuria or renal decline.

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