Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals reviewed in this issue

Am J Sports Med*
ANZ J Surg*
Aust Fam Physician*
Br J Fam Plann*
Br J Gen Pract*
Br J Sports Med*
Can Fam Physician Med Fam Can*
Evidence-Based Medicine*
J Fam Pract*
JAMA*
Lancet*
Pediatrics*
Physician and Sportsmedicine*
Postgrad Med*
* Journals indexed in Index Medicus

Alcohol and Substance Abuse

21-400 Going where the epidemic is: Epidemiology and control of hepatitis C among injecting drug users.

Crofts N. Aust Fam Physician. May 2001.
Vol.30. No.5. p.420-5.
Reviewed by Dr Barry Suckling

Review: Hepatitis C continues to spread among injecting drug users. Other forms of transmission are uncommon. Counselling is the mainstay of treatment, both personal counselling, and peer counselling.

21-401 Naltrexone and acamprosate: Using new drugs for alcohol dependence.

Tedeschi M. Aust Fam Physician. May 2001.
Vol.30. No.5. p.447-50.
Reviewed by Dr Barry Suckling

Review: Two new drugs for the treatment of alcohol dependence have recently become available. Both have an 'anticraving' action, but act on different pathways. This article gives an outline of their pharmacology and guidelines on their use in general practice.

Alternative Medicine

21-402 Herb-drug interaction guide.

Braun L. Aust Fam Physician. April 2001.
Vol.30. No.4. p.357-8.
Reviewed by Dr Barry Suckling

Review: In an effort to streamline the information on interactions the author has designed two charts. The first lists the 21 most popular herbal medicines sold in Australia. The second lists the 12 most commonly prescribed drug classes.

Comment: This makes interactions very easy to identify. The tables in this article are excerpts from the charts.

21-403 Herb-drug interaction guide.

Braun L. Aust Fam Physician. May 2001.
Vol.30. No.5. p.473-6.
Reviewed by Dr Barry Suckling

Review: Another excerpt from the charts described in the April 2001 journal. See 21-402.

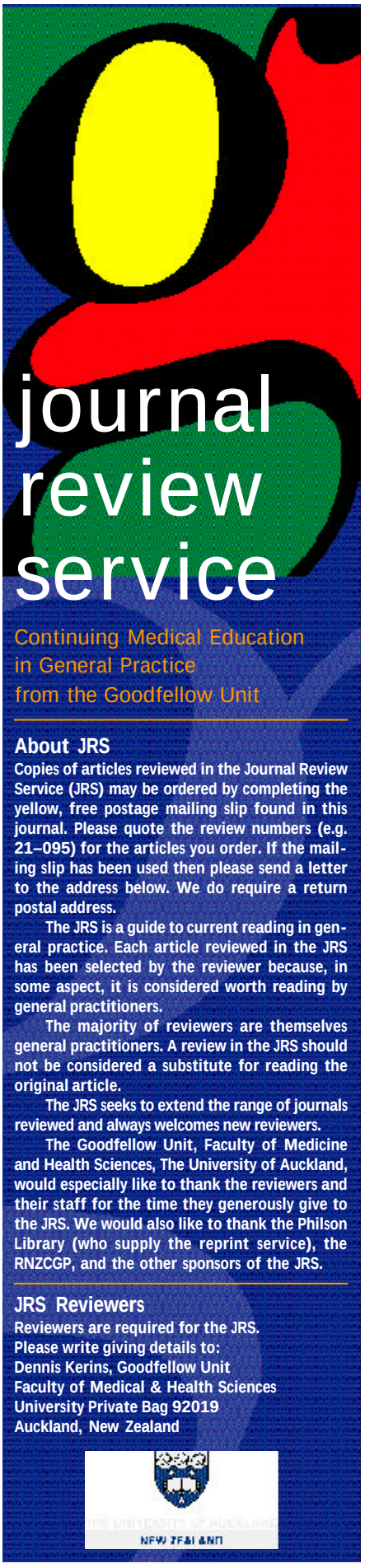
Comment: Good for reference.

Anesthesia and Analgesia

21-404 Regional nerve blocks: Part 1 - an introduction.

Simpson S. Aust Fam Physician. May 2001.
Vol.30. No.5. p.451-4.
Reviewed by Dr Barry Suckling

Review: This is an introduction to a short series of subsequent articles which will cover regional blocks of the head, hand and forearm, foot and



About JRS

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

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

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

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

JRS Reviewers

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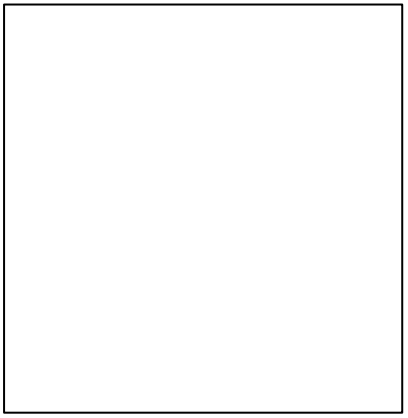
ankle, Bier's block and femoral and intercostal blocks. Small peripheral nerve blocks are easy to do and are as safe as anything else we do.
Comment: A simple approach with techniques and drugs with which you are familiar is most effective.



(photo courtesy NZ Doctor)

Asthma

21-405 Is budesonide or nedocromil superior in the long-term management of mild to moderate asthma in children?

Stella MF, Newton W. J Fam Pract. January 2001. Vol.50. No.1. p.70.
Reviewed by Dr Bruce Adlam
Review: This study provides good evidence that inhaled budesonide or nedocromil may be given to all children with mild to moderate asthma. Increase in height was significantly less for the budesonide group although there was no significant difference in overall growth velocity, Tanner stage or projected final height at the end of the treatment period. (Original article reviewed: N Engl J Med, 2000; 343: 1054-63)

21-406 Onset and persistence of childhood asthma: predictors from infancy.

Klinnert MD, Nelson HS, Price MR, et al.
Pediatrics. October 2001. Vol.108. No.4. p.E69 (electronic version only)
Reviewed by Dr Len Brake
Review: I hesitate to use the adjective myself but this paper has been described as 'seminal'. It is a study of the natural history of childhood asthma following a group of at-risk children from 133 families from prenatal to school years. There is an interesting correlation between parental care, IgE levels and consequent development of asthma. It raises the question of psychological effects on immune levels, etc. The children were from at risk families and 28% developed asthma by school age.
Comment: This is an important paper and will be used as a basis for future studies.

Cardiovascular System

21-407 2000 Canadian hypertension recommendations: Summary of recommendations affecting family physicians.

Canadian Hypertension Recommendations Working Group. Can Fam Physician Med Fam Can. April 2001. Vol.47. p.793-4.
Reviewed by Dr Mike Lyons
Review: Short summary of the year 2000 recommendations of the above Group – an update of the 1999 hypertension recommendations. Provides specific figures on diagnosis, lab tests, treatment and target values.
Comment: Nothing startlingly new for the 1 000 GPs who assimilated the lessons dished out by Prof. Maling in his three Premec case studies. Drug doses not specified.

21-408 Cardiovascular disease and depression.

Schultz R. Aust Fam Physician. March 2001. Vol.30. No.3. p.219-23.
Reviewed by Dr Barry Suckling
Review: Patients with cardiovascular disease have a high prevalence of depression. Depressed patients with cardiovascular disease have worse outcomes. Strategies to reduce or prevent this dual pathology are discussed.
Comment: Screening for depression in cardiovascular patients and treatment will improve the outlook for both.

21-409 Management of deep vein thrombosis.

Chong BH. Aust Fam Physician. March 2001. Vol.30. No.3. p.235-40.
Reviewed by Dr Barry Suckling
Review: A good review outlining treatment to prevent pulmonary embolism, and further recurrence of the thrombosis.

21-410 Diagnosis of heart failure in primary care: an assessment of international guidelines.

Grimshaw GM, Khunti K, Baker R. Br J Gen Pract. May 2001. Vol.51. No.466. p.384-6.
Reviewed by Dr Rob Henderson
Review: The authors performed a comparative assessment on guidelines for managing heart failure. They assessed the guidelines on their rigour of development, their content and application. The authors found the quality of guidelines varied considerably. The authors found some deficiencies in all the guidelines.

Amongst the highest scoring guidelines were the American and Scottish guidelines. The New Zealand guidelines scored ten out of a possible 100 on the rigour of development, the second lowest score.

Comment: Doctors need to be sceptical of guidelines.

21-411 Prediction of all-cause and cardiovascular mortality in elderly people from one low serum thyrotropin result: a 10-year cohort study.

Parle JV, Maisonneuve P, Sheppard MC, et al. Lancet. 15 September 2001. Vol.358. No.9285. p.861-5.

Reviewed by Dr Tony Hanne

Review: A ten-year prospective cohort study of over 1000 people aged 60+ in the UK showed startlingly high rates of sub-clinical hyperthyroidism accompanied by a two-fold increase of risk of death from cardiovascular disease throughout the first five years. The finding of low thyrotropin but normal thyroxine was present in 6%.

Comment: Screening for low serum thyrotropin in older patients is worthwhile. A positive finding may be an indication for radioactive iodine. The main risk is of atrial fibrillation.

21-412 Cost-effectiveness of vitamin therapy to lower plasma homocysteine levels for the prevention of coronary heart disease.

Tice JA, Ross E, Coxson PG, et al. JAMA. 22/29 August 2001. Vol.286. No.8. p.936-43.

Reviewed by Dr Len Brake

Review: A high homocysteine level is identified as a modifiable risk factor in CHD. Since 1998 the FDA has required that all enriched grain products contain folic acid of sufficient level to decrease homocysteine levels. This study looks at the potential effectiveness of this nutritional trial. Grain fortification with folic acid is predicted to reduce CHD events by 8% in women and 13% in men. Over a 10 year period in the USA this is 310 000 fewer deaths from CHD.

21-413 Peripheral arterial disease detection, awareness, and treatment in primary care.

Hirsch AT, Criqui MH, Treat-Jacobson D, et al. JAMA. 19 September 2001. Vol.286. No.11. p.1317-24.

Reviewed by Dr Len Brake

Review: The hypothesis here is that PAD is under diagnosed in general practice. The study assesses the feasibility of detecting PAD in primary care clinics. Assessments were made of 6 900 patients using history and the ankle-brachial index. Using these criteria PAD was detected in 29% of the group (see 21-414 for editorial). Patient page attached.

Comment: These results suggest an under diagnosis of this problem.

21-414 Detection of peripheral arterial disease in primary care.

Ouriel K. JAMA. 19 September 2001. Vol.286. No.11. p.1380-1.

Reviewed by Dr Len Brake

Review: See 21-415.

Communicable Diseases, Infections and Parasites

21-415 Does use of an instant hand sanitizer reduce elementary school illness absenteeism?

Gore J, Lambert JA. J Fam Pract. January 2001. Vol.50. No.1. p.64.

Reviewed by Dr Bruce Adlam

Review: Small crossover study of 420 students. Following some education on the importance of hand washing the two groups which involved teacher supervision, showed a 33% reduction in the first group and a 55% reduction in the second group when compared to respective controls when measuring absenteeism from GI and respiratory illnesses. (Original article reviewed: Fam Med, 2000; 32: 633-68)

Comment: The major benefit may have come from the supervised hand washing rather than the specific sanitiser. The primary care message is the support of mother's message about clean hands.

21-416 Bug busting (wet combing) was less effective than malathion lotion for eliminating head lice in children.

Feldman W. Evidence-Based Medicine. May/June 2001. Vol.6. No.3. p.93.

Reviewed by Dr Bruce Arroll

Review: This study compared malathion (0.5% Derbac in NZ) with wet combing of the hair with a nit comb in children aged 3–14 years. This was to be repeated every 3–4 days for two weeks and if an adult louse was found the course was extended by a further three sessions. Malathion was more effective with only two patients needing treatment to eradicate the lice. (Original paper reviewed: Lancet 2000 Aug; 356: 540-4.)

Comment: Forty per cent of children were cured without malathion and the commentator suggests using the wet comb first to reduce the increasing resistance to insecticides.

Contraception and Family Planning

21-417 What is the risk of venous thromboembolism (VTE) among young women taking third-generation oral contraceptives (OCs) in comparison with those taking contraceptives containing levonorgestrel?

Meurer LN, Slawson JG. J Fam Pract. February 2001. Vol.50. No.2. p.108.

Reviewed by Dr Bruce Adlam

Review: This is a large retrospective cohort observational study which supports a two-fold association of third generation oral contraceptives containing gestodene or desogestrel with venous thrombosis compared with oral contraceptives containing levonorgestrel. However, the authors conclude that since the overall incidence is still quite low for either group 3.8 vs 2.2 per 10 000 person-years, the evidence is not compelling enough to mandate switching current users of third generation oral contraceptives. They do, however, suggest avoiding

gestodene or desogestrel when initiating or changing therapy and await the results of a RCT to determine whether or not to be more proactive. (Original article reviewed: BMJ, 2000; 321: 1190-5)

21-418 Combined oral contraception and cancer.

Tuckey J. Br J Fam Plann. October 2000. Vol.26. No.4. p.237-40.
Reviewed by Dr Sue Bagshaw

Review: Another of the FACT sheets. Excellent review of the COC and cancer.
Comment: Must read if you want to check that your knowledge of cancer and the COC is up to date.

21-419 Contraceptive practices in women with systemic lupus erythematosus and/or antiphospholipid syndrome: What advice should we be giving?

Lakasing L, Khamashta M. Br J Fam Plann. January 2001. Vol.27. No.1. p.7-12.
Reviewed by Dr Sue Bagshaw

Review: Eighty-six women with SLE and/or APS were given a questionnaire about contraceptive use, the outcomes and the advice they were given. Forty-five per cent of the women were given no contraceptive advice after diagnosis. Forty-six per cent were told to avoid the COC. One of the 19 women using the COC at the time of diagnosis of SLE, noticed a 'flare up' and seven of the 32 women with APS on the COC suffered thrombosis. There didn't seem to be much evidence of COC making the SLE worse in this study as opposed to other studies which have, but the incidence of clotting means that this method should not be advised for these patients.
Comment: Good to see a study of these disorders. One of the things to especially look out for when prescribing the COC.

21-420 Repeat use of contraceptive crisis services among adolescent women.

Meyrick J. Br J Fam Plann. January 2001. Vol.27. No.1. p.33-6.
Reviewed by Dr Sue Bagshaw

Review: An overview of the research literature on what happens to women after they have had a negative pregnancy test, used emergency contraception or had an abortion.
Comment: This didn't seem to be a very exhaustive review, but did find that women who do have problems with contraceptive use are failed by the service provision they receive. Worth reading if you are concerned about repeat abortions and how to assist women in using effective contraception.

21-421 Hormonal contraception and migraine.

MacGregor EA. Br J Fam Plann. January 2001. Vol.27. No.1. p.49-52.
Reviewed by Dr Sue Bagshaw

Review: Another of the FACT sheets. Excellent review of the COC and migraine.
Comment: This is the English view which may be different from the American. A controversial area but you will see the conservative view here.

Endocrinology

21-422 Lipid disorders in patients with type 2 diabetes: Meeting the challenges of early, aggressive treatment.

Marcus AO. Postgrad Med. July 2001. Vol.110. No.1. p.111-23.
Reviewed by Dr Chris Milne

Review: Since large vessel disease complications are the commonest cause of death in diabetes, it is worth doing all we can to prevent such complications. Several studies suggest that the degree of CAD event reduction in patients with type 2 diabetes is directly related to the degree of lipid lowering. This author recommends statins plus optimal glycaemic control, with occasional use of fibrates or resins.
Comment: Useful article which summarises the results of five major lipid trials, plus gives useful guidelines. The use of American units for blood levels of lipids is the only confusing feature for New Zealand doctors.

Family Practice

21-423 Designing a consumer friendly practice.

Mann L, Chambers D. Aust Fam Physician. March 2001. Vol.30. No.3. p.241-4.
Reviewed by Dr Barry Suckling

Review: The threat of corporate practice is looming in Australia. The corporates say they are not considering New Zealand – at this stage.
Comment: This article outlines ways of developing the practice activities, philosophy, and culture which satisfies the desires of consumers. By developing these, GPs can maintain the practice style they prefer, even in the face of competition.

21-424 Quality, general practice, and the NHS plan.

Smith LF. Br J Gen Pract. April 2001. Vol.51. No.465. p.262-3.
Reviewed by Dr Rob Henderson

Review: The future NHS blueprint has ambitious plans for GPs and their teams. The new primary care trusts will take on the recruitment and payment of primary care staff and will manage all social and medical care. A skill mix of practice nurses, health visitors, pharmacists, receptionist and mental health workers will all work with the general practitioners. Nurses will perform a triage and refer patients to each of these people. General practitioners will, it is hoped, have more time for things that they are best at, that is diagnosing illnesses and managing the trusts. In the larger plan of things general practitioners will have a wider scope of duties. It is argued that the training of general practitioners should be longer, more comprehensive, and include management if the system is to be a success.
Comment: This is a fascinating article about the health changes in the UK. We can probably expect to see a lot of these ideas filtering through to us.

21-425 General practitioners' perceptions of the appropriateness and inappropriateness of out-of-hours calls.

Smith H, Lattimer V, George S. Br J Gen Pract. April 2001. Vol.51. No.465. p.270-5.
Reviewed by Dr Rob Henderson

Review: Over the past 20 years there has been a five-fold increase in the number of out-of-hours calls to general practitioners. This steep upward trend continues and the number of inappropriate calls seems to be disproportionately high. A survey of general practitioners questioned their beliefs about what was considered an appropriate out-of-hours call and what was not. The study found substantial agreement on what constituted appropriate out-of-hours calls, however, for a proportion of doctors, it was the behaviour of the caller that was important rather than the substance of the call.

Comment: Perhaps the most appropriate solution would be a small charge?

21-426 Rural general practitioners' experience of the provision of out-of-hours care: a qualitative study.

Cuddy NJ, Keane AM, Murphy AW. Br J Gen Pract. April 2001. Vol.51. No.465. p.286-90.
Reviewed by Dr Rob Henderson

Review: Rural practitioners have an especially onerous on call duty. This becomes more of a problem when most general practitioners are showing less commitment to out-of-hours care. This qualitative study found that the on call duty greatly intruded into the GP's social and family life. Attracting locums was a major problem. Doctors found their spouses a considerable support.

Comment: This study supports much of the other research in rural practice.

21-427 Attitudes of patients towards the use of chaperones in primary care.

Whitford DL, Karim M, Thompson G. Br J Gen Pract. May 2001. Vol.51. No.466. p.381-3.
Reviewed by Dr Rob Henderson

Review: The study involved a qualitative study of 18 patients followed by a questionnaire. This study found as many patients who resented the presence of a chaperone as patients who wanted a chaperone. Patients tended to prefer to not have a chaperone when with their regular doctor. The article recommends that patients should be more involved in the decision making process. Men held less strong views about chaperones. A surprisingly high number of women preferred a chaperone with a female doctor.

Comment: This article just shows how complex people are!

21-428 Minimising computer script errors.

Qureshi F. Aust Fam Physician. April 2001. Vol.30. No.4. p.350.
Reviewed by Dr Barry Suckling

Review: A brief one-page article. Although it uses the Australian software 'Medical Director' as its example, some of the points are applicable to all programmes.

21-429 General practice on the internet.

Kidd M. Aust Fam Physician. April 2001. Vol.30. No.4. p.359-61.
Reviewed by Dr Barry Suckling

Review: The internet provides a wealth of health information and a minefield of misinformation. No longer are doctors the custodians of medical information.

Comment: This article explores how the roles of doctor and patient are changing and how we can adapt to the changing expectations of our patients.

Gastroenterology

21-430 The evaluation and treatment of adults with gastroesophageal reflux disease.

Flynn CA. J Fam Pract. January 2001. Vol.50. No.1. p.57-63.
Reviewed by Dr Bruce Adlam

Review: Up to 60% of the adult population gets heartburn or reflux during a given year and approximately 20% of these attend their family doctor accounting for 1% of consultations. Key points are: (1) It can be diagnosed clinically. Upper endoscopy is not very accurate in the diagnosis of GORD. Save invasive testing for the red flags – atypical presentation (e.g. dysphagia, weight loss, bleeding) and non responders; (2) PPIs are effective but more costly than H_2 Blockers – hold for non responders or severe GORD at presentation; (3) For mild to moderate disease H_2 Blockers are appropriate first line treatment; (4) For patients with chronic GORD, intermittent symptom directed treatment is cost effective.

Comment: Quite a good article, however, this topic is well covered in our new soon to be released guideline for dyspepsia. Incidentally if you have ever wondered why your peptic ulcer patients secondary to H Pylori seem to develop GORD symptoms after eradication therapy, there is some evidence that H Pylori may be protective against GORD.

21-431 Misoprostol, double dose H_2 receptor antagonists, and proton pump inhibitors reduce GI ulcers in long term NSAID use.

Talley NJ. Evidence-Based Medicine. May/June 2001. Vol.6. No.3. p.88.
Reviewed by Dr Bruce Arroll

Review: This review studied various GI protective drugs in patients taking non-steroidal anti-inflammatories. Misoprostol, proton pump inhibitors and high dose H_2 antagonists (300 mg BD of ranitidine vs 150mg BD) were protective of both gastric and duodenal ulcers. Regular dose H_2 antagonist protected against duodenal but not gastric ulcer. (Original paper reviewed in: J Rheutamol 2000; 27: 2203-14)

Comment: Double dose H_2 antagonists are the most effective followed by proton pump inhibitors. The commentator said that Misoprostol was the most effective in reducing com-

plications and that none of the studies compared one drug with another.

21-432 Liver toxicity: Could this be a drug reaction?

Ryan M, Desmond P. Aust Fam Physician. May 2001. Vol.30. No.5. p.427-31.
Reviewed by Dr Barry Suckling

Review: In patients who present with liver dysfunction the possibility of an adverse reaction to medications should be considered. Prescription medicines, over-the-counter medicines and alternative medicines are all discussed.

21-433 Gallstones: modern management.

Fletcher DR. Aust Fam Physician. May 2001. Vol.30. No.5. p.441-5.
Reviewed by Dr Barry Suckling

Review: Describes the natural history of gallstones and the advantages and disadvantages of ERCP, laparascopic cholecystectomy and open cholecystectomy.

Health Services

21-434 Becoming an information master: using 'medical poetry' to remove the inequities in health care delivery.

Slawson DC, Shaughnessy AF. J Fam Pract. January 2001. Vol.50. No.1. p.51-6.
Reviewed by Dr Bruce Adlam

Review: More money is spent on health care per person in the US than in any other country for no greater life expectancy. Canada spends half the amount and UK about one third. This article looks at the pitfalls in minimally beneficial but not necessary care. Effectively using valid POEMs gives family physicians the tools to avoid waste. There is a limit on how much we can spend and in the US they have chosen to ration people instead of services. The article consists of a table of six commonly over or under-utilised services that can be addressed by individual clinicians. For interest's sake they are: (1) In primary hypertension only ß-Blockers or a diuretic have been shown to decrease hypertension related morbidity and mortality; (2) Overuse in the management of myocardial infarction. Morbidity and mortality is not better in high service facilities (i.e. cardiac catheterisations compared with those without); (3) Detection and treatment of microalbuminuria has not been shown to decrease the likelihood of developing chronic renal failure or the need for dialysis in people with diabetes; (4) Screening for breast cancer. Some programmes suggest screening the 40–50 year old age group; of 100 000 screened 36 cancers will be identified, 6 000 will have false positive mammograms requiring further investigation; (5) Antibiotic treatment for URTI. Seventy-five per cent of patients receive antibiotics. No viral infection will respond and marginal benefit for otitis media, acute sinusitis and acute bronchitis; (6) Misuse-medication related errors. Medical errors occur in 3 to 4% of all hospitalisation in the US resulting in 44,000 deaths per year.

Comment: Solutions are sought in primary care, with evidence-based medicine (POEMs), patient-centred approaches and making primary care more attractive.

(photo courtesy of NZ Doctor)

Metabolic Diseases

21-435 Diabetic foot ulcers: pathophysiology, assessment, and therapy.

Bowering CK. Can Fam Physician Med Fam Can. May 2001. Vol.47. p.1007-16.
Reviewed by Dr Mike Lyons

Review: Discusses aetiology of diabetic ulcers based on neuropathy and ischaemia. Progresses to clinical assessment of a diabetic's feet and onward to general and topical therapy. Includes a comprehensive table of instructions for patients on foot inspection, bathing, corns and calluses, toenails, socks, shoes and circulation.

Comment: Good article for GPs performing annual diabetic checks. Justifies a neurological assessment confined to ankle reflexes, vibration testing with 128Hz tuning fork and sensation testing with a 10g monofilament.

21-436 Hereditary haemochromatosis: never seen a case?

Emery J, Rose P. Br J Gen Pract. May 2001. Vol.51. No.466. p.347-8.
Reviewed by Dr Rob Henderson

Review: The discovery of the genetic basis of haemochromatosis has led to a new evaluation of the disease. The classical manifestations of the disease such as cirrhosis, diabetes and pigmentation are late manifestations. Usually the patient has had symptoms for ten years or longer before these present. The early symptoms are frequently non-specific such as fatigue, arthralgia, and abdominal pain. A United States study found that two thirds of patients had been given an alternative diagnosis before haemochromatosis was diagnosed. It is important therefore to think of haemochromatosis when patients present with no specific symptoms. The diagnosis is usually made with a raised ferritin and this can be followed up with genetic studies or a liver biopsy in doubtful cases. The treatment of blood letting is effective in halting the progress of the disease. Unfortunately many of the symptoms like arthritis are not reversible. The incidence of the disease is about one in two hundred so each general practitioner should have several cases in their practice if they are not missed.

Comment: This is a good reminder of a not so uncommon condition

Musculoskeletal System

21-437 Fibromyalgia: What is it and now do we treat it?

Littlejohn G. Aust Fam Physician. April 2001. Vol.30. No.4. p.327-33.
Reviewed by Dr Barry Suckling

Review: There are two types of musculoskeletal pain syndrome, those involving pain generation and those involving pain amplification. Fibromyalgia is a pain amplification syndrome. Most fibromyalgia patients are emotionally distressed. Treatment is education, aerobic exercise and stress management.
Comment: A good review.

21-438 Exercise-induced leg pain: sifting through a broad differential.

Korkola M, Amendola A. Physician and Sportsmedicine. June 2001. Vol.29. No.6. p.35-50.
Reviewed by Dr Rob Campbell

Review: A review of most of the conditions causing lower leg pain. The commonest three (i.e. periostitis, stress fractures and compartment syndrome) take most of the article.
Comment: A useful paper if you want to refresh your knowledge of this common complaint. Does not discuss the biomechanical causes enough to be a good paper.

Neurology

21-439 Migraine and hypertension: Is there a relationship?

Prentice D, Heywood J. Aust Fam Physician. May 2001. Vol.30. No.5. p.461-5.
Reviewed by Dr Barry Suckling

Review: The relationship between the two is usually coincidental. However: (1) Poor control of hypertension may increase frequency and severity of migraine. (2) Severe hypertension with a new acute headache requires urgent investigation. (3) Many of the drugs used to treat hypertension may cause headache. (4) Some drugs used to treat migraine may increase hypertension.

Nutrition

21-440 The role of orlistat in weight management.

Marks S. Aust Fam Physician. April 2001. Vol.30. No.4. p.335-8.
Reviewed by Dr Barry Suckling

Review: A review of the actions and efficacy of orlistat (Xenical) with discussion of its place in overall weight management.

21-441 Approaches to vitamin B12 deficiency: Early treatment may prevent devastating complications.

Dharmarajan TS, Norkus EP. Postgrad Med. July 2001. Vol.110. No.1. p.99-105.
Reviewed by Dr Chris Milne

Review: Vitamin B12 deficiency is an important treatable cause of neuropsychiatric problems. The commonest cause appears to be veganism plus aggressive lowering of gastric acid, rather than traditional pernicious anaemia. Since the symptoms of fatigue, weakness, memory loss and depression are common and nonspecific, B12 deficiency should be ruled out, particularly in the elderly.
Comment: Useful article about an important problem. The authors talk of maintenance treatment using intramuscular, intranasal or oral administration of B12. In the New Zealand situation, 1000 mcg every three months as an intramuscular injection is the standard maintenance dose; rarely is more frequent administration required.

Obstetrics

21-442 Should breech babies be delivered vaginally or by planned cesarean delivery?

Newton WP. J Fam Pract. February 2001. Vol.50. No.2. p.105.
Reviewed by Dr Bruce Adlam

Review: This was a well-designed multicentre study, across 26 countries and 2 088 women, which shows that a strategy of planned caesarian section delivery for breech position at term reduces neonatal mortality (NNT=100) and serious neonatal morbidity (NNT =42). (Original article reviewed: Lancet, 2000; 356: 1375-83)

21-443 Are there adverse maternal and neonatal outcomes associated with induction of labor when there is no well-accepted indication?

Harwood MI. J Fam Pract. February 2001. Vol.50. No.2. p.106.
Reviewed by Dr Bruce Adlam

Review: This was a retrospective study of 2 886 women with, therefore, some limitations. It found that women undergoing elective induction without an indication (per ACOG guidelines) are at a slightly increased risk for instrumental delivery. (Number needed to harm NNH=32.) In particular primiparous women are at increased risk for caesarian section. (Number needed to harm NNH=11.) (Original article reviewed: Am J Obstet Gynecol, 2000; 183: 986-94)
Comment: This information might be useful during the decision-making process and discussions with women when considering an elective induction.

21-444 Routine screening for postpartum depression.

Georgiopoulos AM, Bryan TL, Wollan P, et al. J Fam Pract. February 2001. Vol.50. No.2. p.117-22.
Reviewed by Dr Bruce Adlam

Review: A fairly small study using the Edinburgh Post Natal Depression tool to screen for postpartum depres-

sion at six weeks. This resulted in a significant increase in the rate of recognition, diagnosis and subsequent treatment of postpartum depression. It is an excellent tool but I had always felt that this was a little early to detect post natal depression but this study does suggest that a score of 10 or over on the EPBD tool at six week is predictive of post natal depression in the first twelve months.
Comment: There is no 'how to treat' advice in this article.

21-445 Folic acid supplements during pregnancy and risk of miscarriage.

Gindler J, Li Z, Berry RJ, et al. Lancet. 8 September 2001. Vol.358. No.9284. p.796-800.
Reviewed by Dr Tony Hanne
Review: It has been known for some years that folic acid given throughout the first trimester substantially reduces the risk of neural tube defects but the concern had been raised that folic acid use was associated with a higher risk of miscarriage. This Chinese programme to encourage folic acid use in early pregnancy provided a great opportunity in a large group of women, on whom there was very detailed and accurate data, to answer the question. No difference in miscarriage rates was detected.
Comment: The dose used was 400 micrograms, substantially less than is usual in New Zealand but otherwise this result is reassuring. It is often easier to start such scares than to stop them.

Occupational Health

21-446 Carpal tunnel syndrome: modern diagnostic and management techniques.

Kanaan N, Sawaya RA. Br J Gen Pract. April 2001. Vol.51. No.465. p.311-4.
Reviewed by Dr Rob Henderson
Review: Carpal tunnel syndrome is a common problem in general practice and sometimes has an atypical presentation. The diagnosis can often be made clinically but in some cases conduction and other tests are important to confirm doubtful cases. Mild cases often respond to conservative therapy including reduction in wrist activities and night splinting. Steroid injection is often helpful in milder cases and may provide relief for some months. More severe cases require either open or endoscopic surgery.
Comment: The article is probably not going to change your day-to-day management but it is interesting.

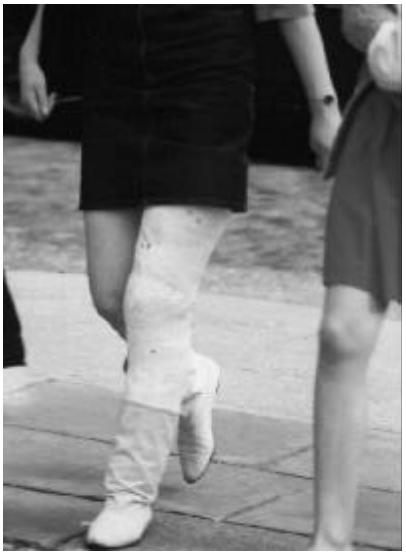
21-447 Management of radiofrequency radiation overexposures.

Hocking B. Aust Fam Physician. April 2001. Vol.30. No.4. p.339-42.
Reviewed by Dr Barry Suckling
Review: The proliferation of antennae on rooftops and near schools has created intense concern among workers in the communications industry, window cleaners, painters and parents. This paper advises on the basic biophysics and health effects of RFR, to guide management of cases.
Comment: Persisting symptoms should not be dismissed as psychosomatic but distinguishing microwave sickness from post-traumatic stress disorders may be difficult.

Oncology

21-448 Faecal occult blood screening reduced the incidence of colorectal cancer.

Rich MM, Sandler RS. Evidence-Based Medicine. May/June 2001. Vol.6. No.3. p.89.
Reviewed by Dr Bruce Arroll
Review: This article reviews the Minnesota study and found that screening for bowel cancer using annual or biennial fecal occult blood tests resulted in 20% fewer cancers. This is the equivalent to screening 2 575 individuals annually to detect one cancer. (Original paper reviewed: N Engl J Med 2000 Nov 30; 343: 1603-7.)
Comment: This study initially reported a 38% colonoscopy result due in part to rehydrating the occult blood slides. The New Zealand guideline group's recommendation was that at present we do not have the resources to offer colonoscopy to one third of the population. It would not be reasonable to commence screening at 50 years of age but it may be OK to screen 65- to 75-year-olds. We will need to wait for the Guideline on high-risk patients.



Orthopedics

21-449 Casting acute fractures: Part 6: the Colles slab.

Spain D. Aust Fam Physician. March 2001. Vol.30. No.3. p.261-4.
Reviewed by Dr Barry Suckling
Review: Safely maintaining reduction with a fully split encircling cast is time intensive and labour intensive. This article describes a near encircling slab as a simpler alternative.

Patients

21-450 User satisfaction: Measurement and interpretation.

Harris J, Westerby M, Hill T, et al. Br J Fam Plann. January 2001. Vol.27. No.1. p.41-5.
Reviewed by Dr Sue Bagshaw
Review: This is a paper presented at the inaugural meeting of the Clinical Effectiveness Unit of the Faculty of Family Planning and Reproduc-

tive Health Care of the Royal College of Obstetricians and Gynaecologists in September 1999. It summarises methods used over the past 10 years and makes suggestions for new approaches to improve clinical effectiveness.

Comment: Must read if you want to explore ways of being more effective, not sure there is much new about some of the suggestions, but it's a good summary.

Pediatrics

21-451 Treatment of childhood phimosis with a moderately potent topical steroid.

Ng W-T, Fan N, Wong CK, et al. ANZ J Surg. September 2001. Vol.71. No.9. p.541-3.
Reviewed by Dr Len Brake

Review: Boys aged from 3–13 with phimosis were treated with twice daily foreskin retraction (within limits of pain) and application of triamcinolone cream. The resulting 84% success rate after six weeks is very satisfying. Good parental cooperation is essential, of course.

Comment: The conclusions are: 'a safe and effective treatment of childhood phimosis'.

Preventive Medicine and Screening

21-452 When should we stop mammography screening for breast cancer in elderly women?

Parnes BL, Smith PC, Conry CM. J Fam Pract. February 2001. Vol.50. No.2. p.110-1.
Reviewed by Dr Bruce Adlam

Review: There is insufficient evidence for a routine screening mammography beyond age 69. For every 1 000 women screened older than age 70 years, 81 mammograms will show an abnormal result, requiring 79 follow up tests, 26 biopsies to detect 11 cancers which may be less aggressive. Unfortunately there are no RCTs in this age group so other factors to consider are comorbidities and patient preference. The US Preventative Services Task Force recommendation is there is no evidence of benefit for women over the age of 75 but recommend screening for women older than 70 who have reasonable life expectancy. Grade of recommendation: C – based on retrospective cohort studies.

21-453 Effects of physical activity counseling in primary care: The activity counseling trial: A randomized controlled trial.

The Writing Group for the Activity Counseling Trial Research Group. JAMA. 8 August 2001. Vol.286. No.6. p.677-87.
Reviewed by Dr Len Brake

Review: No one argues about the effectiveness of physical exercise for health. This study looks at ways of getting patients involved in physical exercise. Physician advice or more active encouragement to participate? In fact there was little difference between the two counselling approaches. At the end of 2 years 91% of the sample of 700 had taken part in some exercise and 77% had completed cardiorespiratory measurements. See also 21-454.

21-454 Physical activity counseling in primary care: the challenge of effecting behavioral change.

Wee CC. JAMA. 8 August 2001. Vol.286. No.6. p.717-9.
Reviewed by Dr Len Brake

Review: See 21-453.

Primary Health Care

21-455 Care of the secondary patient in family practice: A report from the ambulatory sentinel practice network.

Orzano AJ, Gregory PM, Nutting PA, et al. J Fam Pract. February 2001. Vol.50. No.2. p.113-6.
Reviewed by Dr Bruce Adlam

Review: An interesting article on the content of care for another individual other than the primary patient. The article describes the potentially time-consuming and complex services that are largely not reimbursed or recognised. It is, however, a widely used access to care and represents an added value provided by family physicians in approx 6% of consultations in this North American environment.

Comment: In this study 15% of the 'second' consultations were instigated by the physician and extra billing occurred in only 5%.

21-456 The quality of physician-patient relationships: Patients' experiences 1996-1999.

Murphy J, Chang H, Montgomery JE, et al. J Fam Pract. February 2001. Vol.50. No.2. p.123-9.
Reviewed by Dr Bruce Adlam

Review: Ignore the lack lustre title and read this in conjunction with the next article on switching doctors (see 21-457). Substitute the title for 'What patients want' and these articles, plus the commentary (see 21-458) provided, are the missing implementation link for NZ Health Strategy. Which, if these studies are correct, will miss its mark in providing a service that people want.

This study included 2 383 insured adults who remained with one primary care physician throughout the study period of three years while investigators examined how patients respond to a changing health care environment. They utilised eight primary care assessment survey scales (PCAS): four relationship scales – communication, interpersonal treatment, physicians knowledge of the patient, patient trust, and four organisational scales – financial access, organisational access, visit-based continuity, integration of care.

There were significant declines in three of the four indices of physician-patient relationship, and two of the four indices of organisational features of care. There were no significant changes in financial access and integration of care indices. There is a brief discussion of the scales which are similar to those used by RNZCGP. There is good discussion which reasserts that the sustained physician-patient relationship is linked to important outcomes of care that include

compliance, and clinical outcomes. It concludes that declines in primary care performance are demonstrated, and these declines have been reported in an environment of change. The driving factors are not known but some suggestions are the distractions of organisational restructuring, mergers and departures, and pressures to increase productivity without compromising care. There are warnings that goals of health care reform through the advancement of primary care are at risk of being undermined.

Comment: But wait there's more! (see 21-457 and 21-458)

21-457 Switching doctors: predictors of voluntary disenrollment from a primary physician's practice.

Safran DG, Montgomery JE, Chang H, et al. J Fam Pract. February 2001. Vol.50. No.2. p.130-6.
Reviewed by Dr Bruce Adlam

Review: The same study group (see 21-456) was used in a longitudinal study to evaluate eight interpersonal and structural features of care as predictors of patients switching doctors (excluding the 5% who left involuntarily because the physician had moved, retired, died etc. or the patient moving a substantial distance). One fifth (20%) of patients switched doctors. All eight scales predicted switching doctor outcomes with somewhat larger effects associated with the four relationship quality measures – in particular a quality relationship and continuity. There is very good discussion around the findings and conclusions that attributes that predict loyalty to a physician's practice may get overlooked as pressure increases on clinicians and health care organisations to attend to factors such as market share, productivity, and efficiency.

Comment: The bottom line is not the bottom line if it ignores that the essence of medical care delivery involves the interaction of one human being with another.

21-458 What patients want.

Scherger JE. J Fam Pract. February 2001. Vol.50. No.2. p.137.
Reviewed by Dr Bruce Adlam

Review: Putting that all together (see 21-456 and 21-457). This is summed up in this wise commentary by Joseph Scherger. He runs an analogy with Mel Gibson in 'What Women Want', where the lead character is transformed by being able to hear women's thoughts. What if we could hear our patients' thoughts? Think of your own thoughts when you are in someone's waiting room: 'Is this the right person for...?' 'Do I want to entrust my...to them?', 'Tacky magazines', 'I can hear everything that receptionist is saying. I wonder if the person on the other end realises their conversation is so public', might suggest a few. How might we change if we knew? These two articles, plus another very good article in the same journal in July 2000 last year, examining the new evidence on the 'placebo response', validate the core elements of the physician-patient relationship which, in North America anyway, are eroding. Patient care is fundamentally based on human interaction, and although health care systems think management, people want healing. Healing requires healing relationships. Scherder concludes that those who will succeed will be those who give patients what they want and GPs should be encouraged by these validating studies. He finishes with four old adages to consider: (1) Patients want the 3 'A's'; accessibility, affability, and ability in that order, (2) Patients do not care how much you know until they know how much you care, (3) It is much more important to know what sort of patient has a disease than what sort of disease a patient has, (4) The secret of caring for the patient is *caring* for the patient.

Comment: Good value, positive and endorsing for general practitioners. If as physicians we ignored the evidence around aspirin as much as health care delivery organisations and policy makers continue to ignore the evidence around the primary care physician-patient relationship, we would all face censure from our medical disciplinary bodies. What is disturbing is that a step in the right direction in gaining Community and Maori input into our District Health Boards does not guarantee systems that support the sustained physician-patient relationship. What DHBs (under MOH direction) see as patient-centred, is still focused on populations or subsets of populations, and yet it is support for these relationships which is the mechanism by which the primary care strategy can make a difference and give people what they want.

Procedures and Techniques

21-459 Office management of minor wounds.

Gouin S, Patel H. Can Fam Physician Med Fam Can. April 2001. Vol.47. p.769-74.
Reviewed by Dr Mike Lyons

Review: Review of this common GP practice. Evaluates cleansing agents, place of antibiotics, dealing with bite wounds, skin tapes, and tissue adhesives.

Comment: Most GPs will have their own protocol for management of minor wounds. This article may challenge or offer support to these protocols. The details of high-pressure saline irrigation for bite wounds include: 30–35 ml syringe fitted with 18–20 plastic catheter or needle, tip 2 cms above intact skin and using at least 200 mls of saline.

Psychiatry and Psychology

21-460 Depression in men.

Morgan H. Aust Fam Physician. March 2001. Vol.30. No.3. p.206-17.
Reviewed by Dr Barry Suckling

Review: The suicide rate is five times higher for men than women, yet the rate of depression is twice as great in women.

Comment: A good article. It looks separately at young, middle aged, old, and very old men. Advice on screen-

ing and choice of drugs. Greatest frequency in middle age. Greatest risk of suicide in young and very old.

21-461 Are doctors immune to depression?

Parsons J. Aust Fam Physician. March 2001. Vol.30. No.3. p.225-31.
Reviewed by Dr Barry Suckling

Review: Doctors get depression. Personality traits, coping styles and work stresses create particular risks. Denial, stigma, and late presentation, are all barriers to obtaining help.

21-462 The Othmer and DeSouza test for screening of somatisation disorder: is it useful in general practice?

Zaballa P, Crega Y, Grandes G, et al. Br J Gen Pract. March 2001. Vol.51. No.464. p.182-6.
Reviewed by Dr Rob Henderson

Review: Somatisation disorder is a difficult condition to diagnose in general practice. Previous studies have found the Othmer and DeSouza test useful for detecting somatisation. The use of this test is recommended by the American Psychiatric Association. In this study the test was administered to 144 patients assisted by trained psychiatrists. The study found that the test did not help in the detection of somatisation in general practice.

Comment: An interesting article if this is your field of interest.

21-463 Coping with depression: a pilot study to assess the efficacy of a self-help audio cassette.

Blenkiron P. Br J Gen Pract. May 2001. Vol.51. No.466. p.366-70.
Reviewed by Dr Rob Henderson

Review: A self-help 'audio cassette' on coping with depression was produced and widely distributed as part of the British 'beat depression' campaign. The cassette relies on cognitive behavioural techniques. The author assessed the use and value of the cassette in fifty patients diagnosed as having depression. The cassette was found to be a useful addition and the majority of patients were motivated to practice the audio cassette's coping strategies at home. Attitude and knowledge about depression were improved significantly, more so in those not taking antidepressant medication.

Comment: Probably a very cheap form of therapy for depression.

21-464 A qualitative study on patients' views on anxiety and depression.

Kadam UT, Croft P, McLeod J, et al. Br J Gen Pract. May 2001. Vol.51. No.466. p.375-80.
Reviewed by Dr Rob Henderson

Review: A total of 27 patients were identified as having anxiety and depression and their views on the subject were obtained in a study using qualitative methods. Patients' experiences were dominated by the struggle to control unwelcome and obtrusive thoughts and to live in a hostile and threatening world. There was a particular scepticism about drug therapy and a preference for counselling and complementary therapies. These views contrast with current professional emphasis on anxiety and depression management, and need to be considered if there is going to be an improvement in the care of these patients.

Comment: This is excellent practical research. All GPs would find this article helpful in understanding their patients.

21-465 Origins of the desire for euthanasia and assisted suicide in people with HIV-1 or AIDS: a qualitative study.

Lavery JV, Boyle J, Dickens BM, et al. Lancet. 4 August 2001. Vol.358. No.9279. p.362-7.
Reviewed by Dr Tony Hanne

Review: Two striking themes emerge from in-depth interviews with AIDS sufferers most of whom were already seeking assisted suicides. What made continuing life unacceptable to them was firstly the prospect of loss of function, and therefore dignity, and secondly the loss of community.

Comment: These findings are a very telling insight into what may often be the medical, nursing and society shortcomings of terminal care. If we want to stem the growing tide of demands to legalise euthanasia we might do well to reflect on how we help those who have no hope of recovery. Significantly those who work in hospices, where the very issues raised in this study are dealt with so well, report that they almost never hear a request for euthanasia.

21-466 Adult onset of major depressive disorder in relation to early life violent victimisation: a case-control study.

Wise LA, Zierler S, Kriger N, et al. Lancet. 15 September 2001. Vol.358. No.9285. p.881-7.
Reviewed by Dr Tony Hanne

Review: Some 300 women ages 36–45 who had experienced major depression were compared with 600 controls. The incidence of recalled violence in childhood was about double in those who later became depressed. Either physical or sexual violence had similar effects. Both forms of violence combined, aggravated the risk as did the length and severity of the abuse.

Comment: This finding comes as no surprise although it is difficult to separate abuse from other aspects of emotional deprivation such as absent birth fathers.

Research Design and Methodology

21-467 Hypothesis: the research page. Part 2: Confidence intervals and P values.

Godwin M. Can Fam Physician Med Fam Can. May 2001. Vol.47. p.1044-5.
Reviewed by Dr Mike Lyons
Review: Succinct two-page article explaining the importance and relevance of confidence intervals and P values.
Comment: Message reinforced by working through the relative risk, confidence intervals and P values of five fictitious studies. Merits a second read.

Respiratory System

21-468 Do back-up antibiotic prescriptions for the treatment of common respiratory symptoms alter fill rates and patient satisfaction?

Segars LW, Castleman S. J Fam Pract. February 2001. Vol.50. No.2. p.177.
Reviewed by Dr Bruce Adlam
Review: Yes by 15%. In this prospective study of 947 patients 46.6% did not receive a prescription, 23.2% received an immediate fill prescription, and 30.2% received a back up prescription. Of those receiving the back up prescription 96.1% were satisfied by their medical care and only 50.2% filled their prescription giving an absolute reduction of 15%.
Comment: A step in the right direction.

21-469 Diagnosis and prognosis of lower respiratory tract infections: a cough is not enough.

Verheij T. Br J Gen Pract. March 2001. Vol.51. No.464. p.174-5.
Reviewed by Dr Rob Henderson
Review: A cough is the most frequent presenting complaint in general practice. There is, however, much uncertainty over the diagnosis or treatment of patients with an acute cough. A distinction is often made between upper or lower respiratory tract infections, however, in practice the distinction is not clear-cut. A recent study of lower respiratory tract infections found that when using sophisticated techniques, pathogens could be found in up to 55% of the patients. Other studies using X-rays enabled a diagnosis of pneumonia to be made in 6% of cases. The truth, however, is that none of these investigations are available to general practitioners and clinical examination has been shown to be of little value. Some types of patients with a chest infection are more likely to develop pneumonia or require hospitalisation. These include people with chest or cardiac or other debilitating illnesses. These patients probably benefit from antibiotics. A study in the United Kingdom found that about 70% of people with lower respiratory infections were given antibiotics by British general practitioners. The reasons for this were complicated. Antibiotics are probably still over prescribed but we still know very little about the common lower respiratory infection.
Comment: This is an informative and balanced review of the coughing patient (see 21-470).

21-470 Symptoms, signs, and prescribing for acute lower respiratory tract illness.

Holmes WF, Macfarlane JT, Macfarlane RM, et al. Br J Gen Pract. March 2001. Vol.51. No.464. p.177-81.
Reviewed by Dr Rob Henderson
Review: See 21-469.

Rheumatic Diseases

21-471 What's new in rheumatoid arthritis? An evidence based review.

Ostor AJ, McColl GJ. Aust Fam Physician. April 2001. Vol.30. No.4. p.314-20.
Reviewed by Dr Barry Suckling
Review: Over the past 10 years there has been a significant change in the management of rheumatoid arthritis, with improved outcomes. Disease modifying anti-rheumatic drugs (DMARDs) should be commenced early and continued indefinitely. Simple DMARD therapy may be sufficient in some patients, but combinations, particularly those which include methotrexate, improve outcomes.
Comment: Newer therapies promise to further improve these outcomes.

21-472 Rheumatological symptoms: Will investigation make a difference?

Barraclough D. Aust Fam Physician. April 2001. Vol.30. No.4. p.322-6.
Reviewed by Dr Barry Suckling
Review: Discusses which investigations are appropriate in assessing a variety of symptoms, and how to interpret the results.
Comment: Few tests are 'diagnostic'. Interpretation of false positives and false negatives is discussed. Monitoring is usually clinical. Where tests are useful is discussed.

Sexually Transmitted Diseases

21-473 Feasibility of patient-collected vulval swabs for the diagnosis of Chlamydia trachomatis in a family planning clinic: A pilot study.

Macmillan S, McKenzie H, Glett G, et al. Br J Fam Plann. October 2000. Vol.26. No.4. p.202-6.
Reviewed by Dr Bruce Adlam
Review: One hundred and fifty-two women under 25 years attending an urban family planning clinic were invited to participate and 103 were tested both by self insertion of a swab about 0.5cm inside the introitus, and a first void urine sample. Both samples were analysed using LCR assay techniques. There were no demographic differences between the group who declined and those who accepted. Reasons given for declining screening were important to take heed of. The prevalence of Chlamydia was 11%, there was little difference between the sensitivity and specificity of the two methods of collection. Acceptability of the self-collection swab was high but more women would choose urine sampling if asked to be screened again. There are advantages in transporting vulval specimens compared to urine.
Comment: Worth reading if you think we need to be doing more Chlamydia screening and thinking outside the square in terms of ways of doing it.

Smoking

21-474 Enhancing smoking cessation of low-income smokers in managed care.

Wadland WC, Soffelmayr B, Ives K. J Fam Pract. February 2001. Vol.50. No.2. p.138-44.
Reviewed by Dr Bruce Adlam

Review: Forget about the 'managed care' in the title. I would have deliberately left it out to avoid the instant dismissive thoughts of many NZ practitioners. This is quite an interesting article, and poverty is poverty anywhere in the world in whatever health system. Again a small study with some flaws but it does suggest that smoking cessation rates are enhanced in a population of very low-income smokers where individualised telephonic counseling is provided. Quit rates at three months were 21%. (There were no six or 12 month quit rates but these are consistent with other Medicaid studies.) There was 99% usage of nicotine patches and $50.00 incentive to verify self reported smoking cessation at three months.

Comment: The Hillary Commission has already demonstrated they have the infrastructure and experience to provide centralised telephonic services.

Sports and Sports Medicine

21-475 The use of local anaesthetic injections in professional football.

Orchard J. Br J Sports Med. August 2001. Vol.35. No.4. p.212-3.
Reviewed by Dr Chris Milne

Review: The use of local anaesthetics to enable players to take the field whilst recovering from certain injuries is both widespread and controversial. The author makes a compelling argument for the use of injections in most cases where the injection is likely to increase the number of games where a player can take the field in his or her career.

Comment: Useful commentary on a complex problem. As an Olympic doctor, I can administer a pre event local anaesthetic injection to an athlete, as a rugby doctor I am prohibited from doing so by current International Rugby Board rules.

21-476 Exercise and outdoor ambient air pollution.

Carlisle AJ, Sharp NC. Br J Sports Med. August 2001. Vol.35. No.4. p.214-22.
Reviewed by Dr Chris Milne

Review: Comprehensive review article stating the risks posed by exposure to carbon monoxide, nitrogen oxides, ozone, particulate matter, sulphur dioxide and volatile organic compounds. Best advice is to exercise away from traffic, avoid the rush hour, and if it is cold and smoggy, exercise indoors.

Comment: Common sense conclusions in a detailed article. They also mention that 'on hot bright days' in the United Kingdom, elevated levels of O_3 (ozone) may occur, which can be avoided by running/cycling in the early morning or late evening. From a personal perspective, having spent a year in the UK whilst I was running most days, I'd advise people to get out on any sunny day there was, as there were precious few of them!

21-477 Overtraining: Making a difficult diagnosis and implementing targeted treatment.

Uusitalo AL. Physician and Sportsmedicine. May 2001. Vol.29. No.5. p.35-50.
Reviewed by Dr Rob Campbell

Review: A reasonable review of this problem which is common in endurance athletes, difficult to diagnose with easy objective tests and best treated by prevention. There are no definitive diagnostic tests and the symptoms are the most reliable diagnostic features.

Comment: A useful summary paper of this difficult problem. Excluding medical, nutritional and psychological causes is important – especially depression.

21-478 Articular cartilage injuries of the knee: evaluation and treatment options.

LaPrade RF, Konowalchuk BK, Fritts HM, et al. Physician and Sportsmedicine. May 2001. Vol.29. No.5. p.53-9.
Reviewed by Dr Rob Campbell

Review: This article explores the assessment and management of articular cartilage injuries not degenerative conditions. It describes the MRI techniques for more accurate diagnosis and possible surgical techniques for management.

Comment: Interesting stuff regarding some of the cartilage implant or grafting techniques, but there are still no long term reliable prognosis studies.

21-479 Sports and Marfan syndrome: Awareness and early diagnosis can prevent sudden death.

Salim MA, Alpert BS. Physician and Sportsmedicine. May 2001. Vol.29. No.5. p.80-90.
Reviewed by Dr Rob Campbell

Review: A review of this autosomal dominant condition with significant effects on mortality. It discusses the sports related issues and restrictions of certain dynamic activities.

Comment: If you have patients with this syndrome this is a good reference paper to have in your office.

21-480 Intrinsic and extrinsic risk factors for muscle strains in Australian football.

Orchard JW. Am J Sports Med. May/June 2001. Vol.29. No.3. p.300-3.
Reviewed by Dr C Hanna

Review: This paper reports the analysis of 83 503 player-games over an eight year period. Hamstring, quadriceps and calf strains were the most common muscle strain injuries reported.

Comment: The greatest risk factor for a muscle strain was a history of a similar previous injury.

Urology

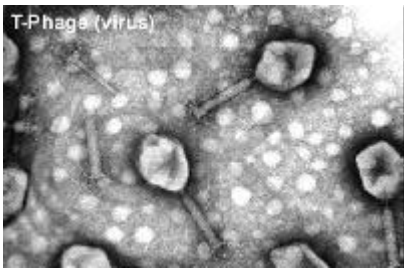
21-481 Urinary tract infection: Are we getting it right?

Wijesinha SS. Aust Fam Physician. April 2001. Vol.30. No.4. p.343-5.
Reviewed by Dr Barry Suckling

Review: A lack of strict diagnostic criteria often leads to over treatment of inconsequential infections, and also inadequate action with potentially serious infections.
Comment: Discusses who should be treated and who should be investigated.

21-482 Markedly raised serum prostate specific antigen levels: Prostatic infarction rather than malignancy?

Kiran PR. Aust Fam Physician. May 2001. Vol.30. No.5. p.458-60.
Reviewed by Dr Barry Suckling
Review: The higher the levels, the more likely is malignancy. However this paper describes five patients who presented with retention and very high PSA levels, who had prostatic infarction and chronic prostatitis on histology.



Virus Diseases

21-483 Viral hepatitis? Which test should I order?

Sheorey H, Waters MJ. Aust Fam Physician. May 2001. Vol.30. No.5. p.433-7.
Reviewed by Dr Barry Suckling
Review: A multitude of viruses may cause hepatitis. This article outlines tests that will help determine which virus.
Comment: Also summarises prevention and treatment strategies.

21-484 Algorithm for serodiagnosis of viral hepatitis (VH)

Aust Fam Physician. May 2001. Vol.30. No.5. p.440.
Reviewed by Dr Barry Suckling
Review: Just as the title says. A one page article which summarises the article 'viral hepatitis? which tests?' See 21-483.
Comment: Good for reference.

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