Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

BMJ*
Br J Sports Med*
Can Fam Physician Med Fam Can*
Evidence-Based Medicine*
Intern Med J*
J Fam Pract *
JAMA*
Lancet*
New Zealand Journal of Sports Medicine
Postgrad Med*
*Journals indexed in Medline

Alternative Medicine

22-405 Ginkgo for memory enhancement: a randomized controlled trial.

Solomon PR, Adams F, Silver A, et al. JAMA. 21 August 2002. Vol.288. No.7. p.835-40.
Reviewed by Dr Len Brake

Review: Sold over the counter to enhance and improve memory this six week placebo controlled trial evaluates these claims.

Comment: I'm not one to give the game away but it is unlikely to surprise that in fact gingko provides no measurable benefit in memory or other related cognitive function.

Asthma

22-406 Long-term relation between breastfeeding and development of atopy and asthma in children and young adults: a longitudinal study.

Sears MR, Greene JM, Willan AR, et al. Lancet. 21 September 2002. Vol.360. No.9337. p.901-7.
Reviewed by Dr Tony Hanne

Review: Over 1 000 children born in Dunedin in 1972–3 were followed up every 2–5 years from ages nine to 26 looking for evidence of allergy to cats, house dust or grass pollens, and for a history of asthma. Approximately half had been breast fed for at least four weeks. A substantially higher proportion of the breast fed babies subsequently developed atopy or asthma than those who were bottle fed, irrespective of whether there was a family history of these conditions. See commentary 22-407.

Comment: Just when we thought we had a cast-iron case for breastfeeding along comes this study which throws the argument into confusion. Earlier research had produced conflicting results, but most of us have been advocating breastfeeding as a safeguard against asthma. What is now becoming clear is that breastfeeding reduces the risk of asthma before two years but increases it after nine. How on earth are we going to explain this to mothers-to-be in order to allow them to make informed decisions?

22-407 Breast is best for preventing asthma and allergies – or is it?

Sly PD, Holt PG. Lancet. 21 September 2002. Vol.360. No.9337. p.887-8.
Reviewed by Dr Tony Hanne

Review: See 22-406.

22-408 Asthma management: how effective is it in the community?

Matheson M, Wicking J, Raven J, et al. Intern Med J. September/October 2002. Vol.32. No.9/10. p.451-6.
Reviewed by Dr Helen Moriarty

Review: An Australian survey of 435 subjects who self-identified as 'ever' having had asthma. The paper concluded that asthma management falls well short of guidelines. This was based on patient self-report of peak flow or other respiratory monitoring or asthma action plans.

journal review service

Continuing Medical Education in General Practice from the Goodfellow Unit

About JRS

Copies of articles reviewed in the Journal Review Service (JRS) may be ordered by completing the yellow, free postage mailing slip found in this journal. Please quote the review numbers (e.g. 21–095) for the articles you order. If the mailing slip has been used then please send a letter to the address below. We do require a return postal address.

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

Reviewers are required for the JRS. Please write giving details to:
Dennis Kerins, Goodfellow Unit
Faculty of Medical & Health Sciences
University Private Bag 92019
Auckland, New Zealand

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

Comment: Of course NZ is not like Australia! However, in the Aussie defense, the methodology was not a good one to determine current community asthma management.

22-409 Inadequately controlled asthma: patients do not understand their treatment plans.

Kaplan A. Can Fam Physician Med Fam Can. August 2002. Vol.48. p.1280-2.
Reviewed by Dr Mike Lyons
Review: See 22-410.

22-410 Case Report: Cough variant asthma.

D'Urzo A, Jugovic P. Can Fam Physician Med Fam Can. August 2002. Vol.48. p.1323-5.
Reviewed by Dr Mike Lyons
Review: These three articles are part of a symposium on asthma. (See 22-409 and 22-463.) The first (editorial) outlines an approach to chronic cough and emphasises patient education and the writing of an action plan. Family physicians in Ontario are mandated to develop action plans. The second article discusses postnasal drip syndrome, asthma and gastroesophageal reflux disease as the three commonest causes of cough. The third article is a succinct case report of a 32-year-old patient with cough variant asthma.
Comment: Revisions of the basics. May be good to use as an audit tool in a year to see how well we absorbed the information distributed this month by the New Zealand Guidelines Group *The diagnosis and treatment of adult asthma* as well as the article *Adults with asthma* in *New Zealand Doctor*. Don't want to cause reading overload!

Cardiovascular System

22-411 Can aspirin prevent cardiovascular events in patients without known cardiovascular disease?

Didden D. J Fam Pract. May 2002. Vol.51. No.5. p.415.
Reviewed by Dr Bruce Adlam
Review: This meta-analysis of randomised controlled trials (RCTs), which included mostly middle-aged men, showed aspirin can prevent a first heart attack in patients without known cardiovascular disease. The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure gives a grade A recommendation for discussing aspirin with men older than 40 years, postmenopausal women, and patients with risk factors for coronary heart disease (CHD), such as hypertension, diabetes, or smoking. (Original article reviewed: Ann Intern Med 2002; 136: 161-72).

22-412 How do calcium channel blockers compare with beta-blockers, diuretics, and angiotensin-converting enzyme inhibitors for hypertension?

Force RW. J Fam Pract. May 2002. Vol.51. No.5. p.482.
Reviewed by Dr Bruce Adlam
Review: Calcium channel blockers are associated with slightly fewer strokes and slightly more myocardial infarctions compared with beta-blockers or diuretics. No significant differences in total or cardiovascular mortality between the classes of medications were noted in this meta-analysis. These data support the notion that calcium channel blockers are as safe as, but no more effective than, conventional treatments for hypertension. In diabetic patients, an angiotensin-converting enzyme (ACE) inhibitor should be used before a calcium channel blocker. (Original article reviewed: J Am Coll Cardiol 2002; 39: 315-22).

22-413 ß-blocker therapy and symptoms of depression, fatigue, and sexual dysfunction.

Ko DT, Hebert PR, Coffey CS, et al. JAMA. 17 July 2002. Vol.288. No.3. p.351-7.
Reviewed by Dr Len Brake
Review: All the rage 25 years, ß-blockers may now be underused. There are proven health benefits in myocardial infarction, heart failure and hypertension. The context of this meta-analysis is that the low use of these drugs represents concerns about the side effects - especially fatigue and impotence. Side effects were analysed in 15 trials involving 35 000 subjects and in summary found that these perceived side effects were much lower than expected.

22-414 Management of chronic heart failure: recent developments.

Cowie MR, Zaphiriou A. BMJ. 24 August 2002. Vol.325. No.7361. p.422-5.
Reviewed by Dr Len Brake
Review: Digoxin has been given the boot and now the diuretic, ace inhibitor and ß-blocker is in fashion for heart failure treatment. With a soupcon of spironolactone if so desired. Early signs of failure are tricky to detect clinically and the echo cardiogram is the gold standard investigation. If you

can, access it. This is a concise update on all aspects of the problem.
Comment: Very helpful.

22-415 Coronary artery bypass surgery versus percutaneous coronary intervention with stent implantation in patients with multivessel coronary artery disease (the Stent or Surgery trial): a randomised controlled trial.

The SoS Investigators. Lancet. 28 September 2002. Vol.360. No.9338. p.965-70.
Reviewed by Dr Tony Hanne
Review: Nearly 1 000 patients from 53 centres in Europe and Canada were followed up for 1–2 years. Approximately half had had CABG and half PTCA. While a higher proportion of PTCA needed a repeat procedure, there was very little difference in mortality or myocardial infarction in the two groups. See commentary 22-416.
Comment: Over the last 10 years stents have become increasingly the usual PTCA treatment with a marked reduction of re-stenosis within one year. Improved technology has made it possible to treat more and more complex multivessel disease in this way. The gap between the two procedures has narrowed dramatically. CABG still carries significantly more operative risk. This could be useful information for our patients who want to know to whom they should listen.

22-416 Surgery or stent? The gap continues to narrow.

O'Neill WW, Grines CL. Lancet. 28 September 2002. Vol.360. No.9338. p.961-2.
Reviewed by Dr Tony Hanne
Review: See 22-415.

22-417 Beyond angioplasty: novel developments in interventional cardiology.

Lowe HC, Burkoff D, Khachigian LM, et al. Intern Med J. September/October 2002. Vol.32. No.9/10. p.470-4.
Reviewed by Dr Helen Moriarty
Review: Easy-to-read, with colour pictures. This discusses future interventions for patients who are not good candidates for PCI, or for whom stents have restenosed. This also suggests that gene therapy in treatment of restenosis, and explains the approach. Drug coated stents are currently available in New Zealand, but are very expensive, and most health insurance policies specifically exclude cover for them.

22-418 Non-ST-segment elevation syndromes.

Santiago P, Tadros P. Postgrad Med. July 2002. Vol.112. No.1. p.47-68.
Reviewed by Dr Chris Milne
Review: Non-ST-segment elevation syndromes are divided into unstable angina and non-Q wave MI (i.e. infarction where there is less than full thickness myocardial damage). Start with anti-ischaemic therapy i.e. oxygen, nitrates, ß-blockers, anticoagulants, and morphine in selected cases. All therapy is aimed at minimising the quantum of infarcted myocardium, so as to improve the prognosis.
Comment: Useful update on an important topic.

22-419 Angiotensin receptor blockers not equivalent to ACE inhibitors for heart failure.

Slawson JG, Meurer LN. J Fam Pract. June 2002. Vol.51. No.6. p.508.
Reviewed by Dr Bruce Adlam
Review: This meta-analysis, combining all relevant trials to date, did not demonstrate a reduction in mortality in patients treated with angiotensin receptor blockers (ARBs) for heart failure. The combination of an angiotensin-converting enzyme (ACE) inhibitor and an ARB may decrease the overall rate of hospitalisation for worsening heart failure, but not mortality. (Original article reviewed: J Am Coll Cardiol 2002; 39: 463-70)
Comment: Physicians should continue to use ACE inhibitors as first-line therapy in heart failure and consider ARBs for patients unable to tolerate ACE inhibitors.

22-420 No benefit to adding warfarin to aspirin after heart attack.

Blakely PF, King VJ. J Fam Pract. June 2002. Vol.51. No.6. p.518.
Reviewed by Dr Bruce Adlam
Review: This study indicates: In patients with an acute myocardial infarction, the combination of low-dose aspirin and standard doses of warfarin, compared with aspirin alone, does not reduce all-cause mortality among a largely male patient population with a relatively high incidence of diabetes and hypertension. Moreover, aspirin monotherapy has a better safety profile than combination antithrombotic therapy. (Original article reviewed: Circulation 2002; 105: 557-63)

22-421 Outpatient treatment of heart failure.

McConaghy JR, Smith SR. J Fam Pract. June 2002. Vol.51. No.6. p.519-25.
Reviewed by Dr Bruce Adlam
Review: Heart failure is a common, costly, and disabling disorder mainly affecting the elderly, and with prevalence rates of up to 10% in patients older than 65 years. Key points are: (1) Control causes and progression by controlling hypertension, diabetes, myocardial ischemia, and tobacco and alcohol use. (2) Treat HF with ACE inhibitors, angiotensin receptor blockers, or beta-blockers, used alone or in combination. Add spironolactone and carvedilol (or change current beta-blocker to carvedilol) in severe CHF. (3) Institute aerobic exercise programme. (4) Control symptoms with diuretics, restricted dietary sodium intake, and digoxin. (5) Provide close follow-up that is comprehensive and multi-disciplinary, including intensive patient education; self-monitoring of weight, symptoms, and blood pressure; and periodic telephone or home visits between surgery visits.
Comment: This is a very good review of current treatments though little to add to the recent review of the NZ Guidelines on Congestive Heart Disease.

22-422 General health screenings to improve cardiovascular risk profiles: A randomized controlled trial in general practice with 5-year follow-up.

Engberg M, Christensen B, Karlsmose B, et al. J Fam Pract. June 2002. Vol.51. No.6. p.546-52.
Reviewed by Dr Bruce Adlam
Review: This well designed population based RCT investigated the impact of general health screenings and discussions with general practitioners on the cardiovascular risk profile of a random population of 2 000 patients. Health screenings reduced the cardiovascular risks in the intervention groups. After five years of follow-up, the number of persons at elevated cardiovascular risk was about half that expected compared with the control group. The impact of intervention was higher among at-risk individuals. Consultations about health did not appear to improve the cardiovascular profile of the study population.
Comment: Worth reading

Dermatology

22-423 Local treatments for cutaneous warts: systematic review.

Gibbs S, Harvey I, Sterling J, et al. BMJ. 31 August 2002. Vol.325. No.7362. p.461-8.
Reviewed by Dr Len Brake
Review: There is a paucity of decent trials but this group have searched and found the best of them. Salicylic acid applied topically had a beneficial effect. There is little evidence for the efficacy of cryotherapy. In summary the best treatment is no treatment unless disfigurement or pain is a problem.

Ear, Nose and Throat

22-424 Control of chronic nasal symptoms: directing treatment at the underlying cause.

Chrostowski D, Pongracic J. Postgrad Med. June 2002. Vol.111. No.6. p.77-95.
Reviewed by Dr Chris Milne
Review: Clear rhinorrhoea, sneezing paroxysm and ocular symptoms strongly suggest allergic rhinitis. The timing of seasonal allergic rhinitis (spring and early summer) may be a clue. Irritants such as tobacco smoke, air pollutants and perfumes may cause non-allergic responses that mimic allergic diseases. Look for structural contributors e.g. septal deviation or polyps. Treatment with nasal corticosteroids, anticholinergic agents, and antihistamines is generally effective.
Comment: Useful summary article.

Emergency Medicine

22-425 Potential impact of public access defibrillators on survival after out of hospital cardiopulmonary arrest: retrospective cohort study.

Pell JP, Sirel JM, Marsden AK, et al. BMJ. 7 September 2002. Vol.325. No.7363. p.515-9.
Reviewed by Dr Len Brake
Review: Within two minutes of cardiac arrest 66% patients have ECG evidence of ventricular fibrillation or tachycardia. The chances of this arrhythmia responding to defibrillation declines as the minutes tick away. This study attempts to evaluate the effect of placing defibrillators in shopping malls, airports etc. to be used by lay people. They say overall survival could rise from 5% to 6.5% at best.

Endocrinology

22-426 How beneficial are thiazolidinediones for diabetes mellitus?

Culhane NS, Graves R. J Fam Pract. May 2002. Vol.51. No.5. p.424.
Reviewed by Dr Bruce Adlam
Review: The answer – the thiazolidinediones pioglitazone (Actos) and rosiglitazone (Avandia) are effective at lowering fasting plasma glucose (FPG) and glycosylated hemoglobin (Hb A1c) in patients with type 2 diabetes when used either as monotherapy or in combination with sulfonylureas, metformin, or insulin. The glucose-lowering effects appear comparable with those of sulfonylureas and metformin alone. Currently, there are no randomised trials directly comparing patient-oriented outcomes of the thiazolidinediones with those of sulfonylureas and metformin. Grade of recommendation: B (on the basis of extrapolations from randomised trials and low quality randomised trials).

22-427 Outcomes of audit-enhanced monitoring of patients with type 2 diabetes.

de Grauw WJ, van Gerwen WH, van de Lisdonk EH, et al. J Fam Pract. May 2002. Vol.51. No.5. p.459-64.
Reviewed by Dr Bruce Adlam
Review: This study looks at a audit on outcomes of care in diabetes involving 49 000 patients between 1992 and 1999, and showed that outcomes of diabetes care in a family practice research setting using an audit enhanced monitoring system (not unlike the National Diabetes programme) were comparable with those reported under randomised controlled trial conditions.
Comment: Will be of interest to IPAs, primary health organisations and disease management programmes.

22-428 Managing an athlete with diabetes.

Dawson T. New Zealand Journal of Sports Medicine. Autumn 2002. Vol.30. No.1. p.26-8.
Reviewed by Dr Rob Campbell
Review: A succinct review of the important issues in the diabetic athlete. All diabetics should be active so this is a good refresher paper to read.
Comment: A good reference paper to have on your shelf.

22-429 Irbesartan was renoprotective in patients with type 2 diabetes, hypertension, and microalbuminuria.

Rabbat CG. Evidence-Based Medicine. May/June 2002. Vol.7. No.3. p.80-3.
Reviewed by Dr Bruce Arroll
Review: This was a placebo controlled study of Irbesarten versus placebo which found that in patients with diabetes, hypertension and microalbuminuria, there was significantly less progression to nephropathy in the Irbesarten group. (Original article reviewed: N Engl J Med 2001; 345: 870-8).
Comment: The commentator makes the point that as yet there are no head

to head studies of ACEs versus angotensin 2 blockers in terms of clinical outcomes. In the meantime stick with the ACEs.

22-430 Losartan was renoprotective in diabetic nephropathy independent of its effect on blood pressure.

Rabbat CG. Evidence-Based Medicine. May/June 2002. Vol.7. No.3. p.82.
Reviewed by Dr Bruce Arroll

Review: This study was a randomised trial of losarten versus placebo. There was a statistically significant reduction in end stage renal failure but no difference in terms of cardiovascular endpoints. (Original article reviewed: N Engl J Med 2001; 345: 861-9)
Comment: The commentator stated that ACEs are still the drug of first choice but that a combination of ACE and angiotensin 2 blockers is promising.

Gastroenterology

22-431 Helicobacter pylori: when is treatment now indicated?

Duggan A. Intern Med J. September/October 2002. Vol.32. No.9/10. p.465-9.
Reviewed by Dr Helen Moriarty

Review: Outlines the reasons for H. pylori eradication. Lists clinical indications for eradication, and gives historical approaches, suggests treatment and diagnostic options.
Comment: A significant cohort of elderly have this infection. The paper suggests that treatment of this group would prevent future complications with savings in morbidity and mortality.

22-432 What is the best way to evaluate acute diarrhea?

Montgomery L, Scoville C. J Fam Pract. June 2002. Vol.51. No.6. p.575.
Reviewed by Dr Bruce Adlam

Review: Limited evidence delineates the relative probabilities of causes of acute diarrhoea, typically defined as a diarrhoeal disease lasting 14 days or fewer, in the developed world. This evidence-based answer recommends that stool culture for bacteria should be considered in patients with community- or travel-acquired diarrhoea, especially when fever or bloody stool is present. Toxin tests for C difficile are only recommended for patients who have become hospitalised. Testing for acute parasitic diseases should be reserved only for patients whose symptoms persist after seven days.
Comment: This study is based in USA and not in NZ which has higher rates of Giardia.

General

22-433 The impaired ageing doctor.

Peisah C, Wilhelm K. Intern Med J. September/October 2002. Vol.32. No.9/10. p.457-9.
Reviewed by Dr Helen Moriarty

Review: A subject close to the hearts of some of us. Our profession is ageing. Practice investments are not what they once seemed. Health is always unpredictable. A short discussion paper from an Australian perspective.
Comment: New Zealand has its own Doctors Health Advisory Service, free, for those who may need help.

Gynecology

22-434 Risks and benefits of estrogen plus progestin in healthy postmenopausal women.

Writing Group for the Women's Health Initiative Investigators. JAMA. 17 July 2002. Vol.288. No.3. p.321-3.
Reviewed by Dr Len Brake

Review: This huge study was assessing the risks and benefits of hormone use in postmenopausal women. On May 31 2002, after five years of follow-up (originally 8.2 years was intended), the board monitoring the study recommended stopping the trial as the statistics for invasive breast cancer exceeded the safe boundaries to pursue the trial any longer. See editorial 22-435.
Comment: In effect the treatment was worse that the complaint. There was higher risks of coronary heart disease and strokes as well.

22-435 Failure of estrogen plus progestin therapy for prevention.

Fletcher SW, Colditz GA. JAMA. 17 July 2002. Vol.288. No.3. p.366-8.
Reviewed by Dr Len Brake

Review: See 22-434.

Metabolic Diseases

22-436 Hemochromatosis: common genes, uncommon illness?

Harrison H, Adams PC. Can Fam Physician Med Fam Can. August 2002. Vol.48. p.1326-33.
Reviewed by Dr Mike Lyons

Review: Claims that in a GP Canadian practice of 2 000 patients there will be five to ten patients who are C282Y homozygotes – the typical genetic pattern of hereditary haemochromatosis. Outlines early and late symptoms and signs. Touches on reasons for underdiagnosis of this disease - the most common hereditary condition in populations of Northern European descent. Explains the biochemical and genetic screening and diagnosis. Addresses the question 'who needs a liver biopsy' and treatment briefly outlined.
Comment: Helped clarify some of my confusion after reading the article on haemochromatosis in the May 2002 issue of *New Ethicals*. Caveat – don't jump too readily to blame 'Tullamore Dew' as the cause of raised transaminases in bacchanalian Irishmen!!

Musculoskeletal System

22-437 Does intra-articular hyaluronate decrease symptoms of osteoarthritis of the knee?

Cubbage K. J Fam Pract. May 2002. Vol.51. No.5. p.411.
Reviewed by Dr Bruce Adlam

Review: Contrary to the assertions of the authors, careful evaluation of the results of this study reveal that hyaluronic acid (HA) injection is no better than placebo in the treatment of osteoarthritis (OA) of the knee. Do not let yourself be fooled when shown this study – the analysis was not carried out across all four groups

and when this was carried out, no benefit could be found. (Original article reviewed: Arch Intern Med 2002; 162: 292-8

Comment: Previous studies have also failed to find a benefit of HA versus placebo.

22-438 Safety and efficacy of S-adenosylmethionine (SAMe) for osteroarthritis: a meta-analysis.

Soeken KL, Lee W-L, Bausell B, et al. J Fam Pract. May 2002. Vol.51. No.5. p.425-30.

Reviewed by Dr Bruce Adlam

Review: This study assessed the efficacy of S-adenosylmethionine (SAMe), a dietary supplement now available in the United States, compared with that of placebo or nonsteroidal anti-inflammatory drugs (NSAIDs) in the treatment of osteoarthritis (OA).This was a meta-analysis of randomised controlled trials. SAMe appears to be as effective as NSAIDs in reducing pain and improving functional limitation in patients with OA without the adverse effects often associated with NSAID therapies.

Comment: Limitations include inconsistency in stated and actual dosage in the OTC preparation. Long-term effectiveness needs to be studied and also whether the mode of action is analgesic, anti-inflammatory or attributable to SAMe alleged antidepressant effect.

22-439 Anterior cruciate ligament reconstruction rehabilitation.

Geertsema C. New Zealand Journal of Sports Medicine. Winter 2002. Vol.30. No.6. p.52-5.

Reviewed by Dr Rob Campbell

Review: The anterior cruciate ligament rupture is now a common sports injury and for those wishing to continue multidirection sports, reconstruction is almost essential. The post-op rehabilitation is vital for a full functional recovery and this has changed over the last few years.

Comment: An excellent review of the current approach to post-op rehabilitation and the time needed before return to sport.

Nutrition

22-440 Are any oral iron formulations better tolerated than ferrous sulfate?

McDiarmid T, Johnson ED. J Fam Pract. June 2002. Vol.51. No.6. p.576.

Reviewed by Dr Bruce Adlam

Review: Evidence based answer: Ferrous salt preparations (ferrous sulfate, ferrous gluconate, and ferrous fumarate) are equally tolerable (Grade of recommendation: A, based on RCT). Controlled-release iron preparations cause less nausea and epigastric pain than conventional ferrous sulfate (Grade A, based on randomised controlled trials), although the discontinuation rates between the two iron formulations were similar. Ferrous sulfate remains the standard first-line treatment of iron-deficiency anemia given its general tolerability, effectiveness, and low cost.

Obstetrics

22-441 Factors associated with weaning in the first three months postpartum.

Schwartz K, D'Arcy HJ, Gillespie B, et al. J Fam Pract. May 2002. Vol.51. No.5. p.439-44.

Reviewed by Dr Bruce Adlam

Review: The aim of this research was to determine the demographic, behavioural, and clinical factors associated with breastfeeding termination in the first 12 weeks postpartum. This interesting prospective cohort study of 946 women indicated older well-educated mothers were more likely to continue breastfeeding. Younger and less well-educated mothers needed encouragement. Mastitis, breast or nipple pain, bottle use, and milk expression in the first three weeks were all associated with cessation. Women who used a bottle for some feedings during weeks four to 12 were less likely to discontinue breastfeeding than women who did not use a bottle. 'Not enough milk' was the most common reason given for early cessation. Of interest is that after the first three weeks, bottles and manual expression are not associated with weaning and may improve the likelihood of continuing breastfeeding, at least until 12 weeks. (See also 22-442)

Comment: A supporting commentary in the same issue by Mindy Smith and Linda French is well worth reading whether we are still 'doing obstetrics' or not, as the demonstrated importance of physician continuity of care should still take precedence over past decisions that have discouraged this feature of our practices. There is encouragement here for general practice to take the initiative, to still provide continuity, to keep up the research, understand the risks, use the art of medicine to create the special opportunities to identify and understand critical issues for new parents. We must still ask the questions and answer the 'whys' or are we going to let an 'underarm bowling' mentality stand in our way.

22-442 Supporting women in the transition to motherhood.

Smith MA, French LM. J Fam Pract. May 2002. Vol.51. No.5. p.449-50.

Reviewed by Dr Bruce Adlam

Review: See 22-441.

22-443 Randomised study of long term outcome after epidural versus non-epidural analgesia during labour.

Howell CJ, Dean T, Lucking L, et al. BMJ. 17 August 2002. Vol.325. No.7360. p.357-8.

Reviewed by Dr Len Brake

Review: The belief that epidurals leave a large number of women with chronic back pain has been around so long as to approach a fact. In reality the trials to date have been unhelpful and inconsistent. There are difficulties in randomising as there also are with crossover. For example from the 369 women recruited, 184 were randomised to receive epidural analgesia and 123 received it, and 185 were randomised to other methods of pain relief but 52 of them had an epidural. But sterling efforts have been made all round and long term follow up found no difference in low back pain incidence.

22-444 The skeleton in pregnancy and lactation.
Reid, IR. Intern Med J. September/October 2002. Vol.32. No.9/10. p.433-4.
Reviewed by Dr Helen Moriarty
Review: Debunks a popular myth that women should worry over bone loss during pregnancy and lactation. There are physiological protective agents which ensure that 'small bone losses in normal pregnancy and lactation' are 'completely reversible'.
Comment: Worth a read (no pun intended). Ian is a New Zealand endocrinologist.

Oncology

22-445 First results from the International Breast Cancer Intervention Study (IBIS-I): a randomised prevention trial.
IBIS investigators. Lancet. 14 September 2002. Vol.360. No.9336. p.817-24.
Reviewed by Dr Tony Hanne
Review: Over 7 000 women between 35–70 who were at increased risk of breast cancer, were randomised to tamoxifen 20mg daily or placebo. The benefit was very clear. There was a 32% reduction in breast cancer in the treated group over four years. The main drawback was the increased risk of thromboembolism in those on tamoxifen, most commonly after surgery. The recommendation was that much of this could be avoided by discontinuing treatment during and after an operation. See commentary 22-446.
Comment: It is clearly not appropriate on the basis of this trial to put all women on tamoxifen. The dilemma will be to decide how great the risk of breast cancer needs to be before considering its use. The problem may be helped by a newer agent, anastrozole, which in trials so far seems to be more effective with fewer side-effects.

22-446 Chemoprevention of breast cancer: a promising idea with an uncertain future.
Kinsinger LS, Harris R. Lancet. 14 September 2002. Vol.360. No.9336. p.813-4.
Reviewed by Dr Tony Hanne
Review: See 22-445.

22-447 Practice tips: Fine needle aspiration of breast lumps.
Delva D, Tomalty L, Payne P. Can Fam Physician Med Fam Can. June 2002. Vol.48. p.1055-6.
Reviewed by Dr Mike Lyons
Review: Describes a method for practising FNA of breast lumps. Can be used in CME sessions with or without an assistant. Two balloons are used and filled with a cup of flour and bath oil. Aspiration is performed with a 10ml syringe attached to 21-gauge butterfly set. Explains how to avoid a dry tap and what to do if it occurs.
Comment: Good Canadian D.I.Y. ingenuity to enable Kiwis to practise in the privacy of their homes (or CME groups) before confronting a patient with confidence.

22-448 Screening decreases breast cancer-specific deaths but not all-cause mortality.
Farmer C, Kane KY. J Fam Pract. June 2002. Vol.51. No.6. p.513.
Reviewed by Dr Bruce Adlam
Review: This study confirms screening mammography's role in the reduction of breast cancer-related deaths. These effects are age dependent and seem to benefit women aged 55 to 69 years. (Original article reviewed: Lancet 2002; 359: 909-19
Comment: What this analysis failed to demonstrate, however, was a significant reduction in overall mortality. That is, despite being diagnosed with breast cancer through mammography, these women still have a similar risk of dying from any cause compared with those who were not screened.

Pharmacology

22-449 HMG CoA reductase-inhibitor-related myopathy and the influence of drug interactions.
Huynh T, Cordato D, Yang F, et al. Intern Med J. September/October 2002. Vol.32. No.9/10. p.486-90.
Reviewed by Dr Helen Moriarty
Review: Case reports from New South Wales centres illustrate the problems that can occur with statin drugs. These drugs are now commonly used in New Zealand for lipid-lowering and cardioprotection. Cytochrome P450 interactions are possible, and renal impairment was also a factor in these cases.
Comment: A salutory tale. Many drugs will interfere with CYP 450 enzyme function and might precipitate statin myopathy.

Practice Management

22-450 Physician assistants in the United States.
Mittman DE, Cawley JF, Fenn WH. BMJ. 31 August 2002. Vol.325. No.7362. p.485-7.
Reviewed by Dr Len Brake
Review: The 1960's shortage of doctors initiated the development of a group of physician assistants to work in association with GPs in the US. With the development of PHOs it is possible that a similar style of assistance could begin in New Zealand. Nurses are apparently not keen on the idea and want to be more independent. Example: Man in late 50s with chest pain. The assistant takes a formulated history, interprets the CXR and ECG and refers to hospital either with or without the doctor's involvement.
Comment: When there is a capped fee given per year for a group of patients this could very well be the face of the future for general practice in New Zealand.

Preventive Medicine and Screening

22-451 Does fecal occult blood screening reduce colorectal cancer morbidity?
Edelist DD. J Fam Pract. May 2002. Vol.51. No.5. p.412.
Reviewed by Dr Bruce Adlam
Review: Use of the faecal occult blood test (FOBT) every other year for 13

years to screen patients aged 45 years to 75 years will save one life for every 559 patients screened. Screening with FOBT does not alter the risk of death from all causes, which is felt by some physicians to be a more unbiased end point than cancer-specific mortality. (Original article reviewed: Gut 2002; 50: 29-32). (See also 22-452)
Comment: This study, and others, suggests that individuals who refuse screening with FOBT may be at increased risk of dying from colorectal cancer (CRC). Special efforts should be made to ensure their participation in screening programmes.

22-452 Do disease-specific mortality effects correlate with all-cause mortality effects in cancer screening trials?

Allmon BM, Lindbloom EJ. J Fam Pract. May 2002. Vol.51. No.5. p.480.
Reviewed by Dr Bruce Adlam
Review: Although disease-specific mortality has been the standard for reporting mortality benefit in cancer screening, it does not necessarily correlate with significant benefits in all-cause mortality. In other words, some cancer screening may decrease deaths due to the screened disease, but patients still die at the same (or even higher) rate despite the screening. Inconsistent results are evident in trials studying mammography screening for breast cancer, faecal occult blood testing for colon cancer, and chest x-ray screening for lung cancer. (Original article reviewed: J Natl Cancer Inst 2002; 94: 167-73). (See also 22-451)
Comment: When deciding whether a screening intervention is potentially beneficial, we may be misled by reports of disease-specific mortality.

22-453 Anti-vaccinationists past and present.

Wolfe RM, Sharp LK. BMJ. 24 August 2002. Vol.325. No.7361. p.430-2.
Reviewed by Dr Len Brake
Review: Edward Jenner was the man. His article to the Royal Society of London in 1796 detailing success in preventing smallpox by injecting 13 people with live infectious material from scabs of people with cowpox was not enthusiastically received by everybody. Anti-vaccination groups have been vocal ever since that time. This is a timely article in the face of a new round of immunisation of New Zealand children for meningitis.
Comment: Too much of a good thing?

Primary Health Care

22-454 What is clinical practice improvement?

Wilson RM, Harrison BT. Intern Med J. September/October 2002. Vol.32. No.9/10. p.460-4.
Reviewed by Dr Helen Moriarty
Review: A useful discussion paper for those who want to make some quality practice improvements. Suggests a useful team approach.
Comment: Perhaps your staff could take the leadership in this one?

Procedures and Techniques

22-455 Efficacy of handrubbing with alcohol based solution versus standard handwashing with antiseptic soap: randomised clinical trial.

Girou E, Loyeau S, Legrand P, et al. BMJ. 17 August 2002. Vol.325. No.7360. p.362-6.
Reviewed by Dr Len Brake
Review: Median duration of time for both cleanups was 30 seconds (this is prior to routine patient care not surgical operations)! The reduction of bacterial contamination for rubbing with alcohol was 83% whereas the reduction with hand-washing was 58%.

Psychiatry and Psychology

22-456 ABC of psychological medicine: Functional somatic symptoms and syndromes.

Mayou R, Farmer A. BMJ. 3 August 2002. Vol.325. No.7358. p.265-8.
Reviewed by Dr Len Brake
Review: Rene Descartes formulated the principle of separation of body and mind and this dualism is now so ingrained in medical thought that accepting the integration of physical and psychological factors in aetiologies is difficult. Especially so in the 'difficult patient' – fibromyalgia, abnormal illness behaviour, chronic fatigue, Tapanui flu - all diagnoses that causes a frission of frustration in the busy GP.
Comment: This is an excellent roundup discussing management, diagnoses and causal factors in this somewhat untidy group of problems.

22-457 Single session debriefing after psychological trauma: a meta-analysis.

van Emmerik AA, Kamphuis JH, Hulsbosch AM, et al. Lancet. 7 September 2002. Vol.360. No.9335. p.766-71.
Reviewed by Dr Tony Hanne
Review: Critical incident stress debriefing (CISD) has become the standard professional response to disasters of whatever magnitude. Of course it works, doesn't it? No, according to this very large, stringent meta-analysis. People who received no intervention were actually less likely to suffer from subsequent stress disorders. It is postulated that CISD may actually interfere with our normal recovery mechanisms including help from grandmothers and other family members. See commentary 22-458.
Comment: After the September 11 attack on the Twin Towers in which 3 000 died, 9 000 grief counsellors descended on New York, three for each fatality. While it can be argued that competence among them may have been variable, this is surely a huge over-reliance on a strategy of unproven value. We are likely to see in NZ and Australia a similar response to the bombing in Bali. Have we missed the point?

22-458 Post-trauma debriefing: the road too frequently travelled.

Gist R, Devilly GJ. Lancet. 7 September 2002. Vol.360. No.9335. p.741-2.
Reviewed by Dr Tony Hanne
Review: See 22-458.

22-459 Several depression screening tools work equally well.

Singh AR, Newton WP. J Fam Pract. June 2002. Vol.51. No.6. p.511.

Reviewed by Dr Bruce Adlam

Review: Depressive disorders are common in primary care, but the optimal approach for diagnosis remains controversial. This information summary compared various depression case-finding instruments suitable for the office setting. Eleven different instruments, including the Beck Depression Inventory, the Zung Self-Assessment Depression Scale, and the Primary Care Evaluation of Mental Disorders were compared. The study provides only fair evidence that depression case-finding instruments perform similarly and fairly well in detecting and ruling out depression with a wide variety of outpatients. For screening, the single question, *'Have you felt depressed or sad much of the time in the last year?'* performs well. (Original article reviewed: JAMA 2002; 287: 1160-70).

Comment: Me? I prefer the Edinburgh Post Natal Scale...seriously! Although not validated outside post natal mothers it's a useful management tool. It is very easy to use, adolescents find it easy to complete by themselves and it provides a useful tool for further inquiry. Besides which it can be stored in the notes and compared later to demonstrate improvement or justify to the patient why they need more expert assistance. Good GP research topic!!

22-460 Switching antidepressant classes often works in treatment-resistant depression.

Nanjagowder VT. J Fam Pract. June 2002. Vol.51. No.6. p.512.

Reviewed by Dr Bruce Adlam

Review: About half the patients who do not respond to an initial trial of either a SSRI or a tricyclic antidepressant (TCA) will respond to some degree when switched to a medication from the other class. Ultimately, however, only about 20% to 30% of these patients will achieve full remission after 16 weeks of therapy with the new agent. Initial non-responders to TCAs were more likely to respond to the SSRI than non-responders to the SSRI who were switched to a TCA. (Original article reviewed: Arch Gen Psychiatry 2002; 59: 233-9)

22-461 Association of higher costs with symptoms and diagnosis of depression.

Callahan EJ, Bertakis KD, Azari R, et al. J Fam Pract. June 2002. Vol.51. No.6. p.540-4.

Reviewed by Dr Bruce Adlam

Review: This prospective study of 508 new adult patients examined the relationships among depressive symptoms, physician diagnosis of depression, and charges for care. Key points: (a) diagnosis of depression is associated with higher costs. (b) failure to diagnose depression may raise laboratory costs.

Comment: These conclusions are not new. In reality depression occuring alone is uncommon in general practice and it usually presents within a mixture of psycho-social and other medical problems

Respiratory System

22-462 How, what, and why of sleep apnoea: perspectives for primary care physicians.

Chung SA, Jairam S, Hussain MR, et al. Can Fam Physician Med Fam Can. June 2002. Vol.48. p.1073-80.

Reviewed by Dr Mike Lyons

Review: Outlines the prevalence and associated morbidity of obstructive sleep apnoea (OSA) in Canada. Mean age of death in untreated patients is 59 years. Subtle symptoms may be irritability, personality change, reduced libido and night sweats, morning headaches, dozing off at meetings or while watching TV as well as the usual report from a partner of loud snoring, choking and restless sleep. Outlines an adaptation of the Berlin Questionnaire with positive predictive value 0.97, specificity 0.97 also and sensitivity 0.54. Suggests screening blood tests and tables advantages and disadvantages of treatment options.

Comment: If you agree with the conclusion: 'the substantial medical, social and economic consequences of untreated OSA: the overwhelming number of patients who have escaped clinical detection: and the likelihood of successful treatment strongly justify screening' – then you should read this article.

22-463 Chronic cough: three most common causes.

D'Urzo A, Jugovic P. Can Fam Physician Med Fam Can. August 2002. Vol.48. p.1311-6.

Reviewed by Dr Mike Lyons

Review: See 22-410.

Rheumatic Diseases

22-464 Right ballpark, wrong base: Assessing safety of NSAIDs.

Shaughnessy AF. J Fam Pract. June 2002. Vol.51. No.6. p.538.

Reviewed by Dr Bruce Adlam

Review: Kivitz and colleagues found that valdecoxib, a Cox-2 inhibitor, produces similar pain relief to the older NSAID naproxen in the treatment of moderate to severe osteoarthritis of the knee. The ulcer rate in naproxen at 12 weeks was 10% compared with 3% in the valdecoxib group. However, a trend is emerging that although the incidence of perforation, obstruction and bleeding is lower with another Cox-2 inhibitor celecoxib at six months. Unpublished data show similar rates between celecoxib, ibuprofen and diclofenac in the second six month period. In real terms one perforation, obstruction, or bleeding would be prevented for every 200 patients treated with a Cox-2 inhibitor rather than a traditional NSAID for a full year.

Comment: General comment by this commentator is that current research does not support a safety or toler-

ability advantage of this class of drugs for most patients over the non-specific NSAIDs. The original research by Kivitz is presented in this issue. See 22-465.

22-465 Randomized placebo-controlled trial comparing efficacy and safety of valdecoxib with naproxen in patients with osteoarthritis.

Kivitz A, Eisen G, Zhao WW, et al. J Fam Pract. June 2002. Vol.51. No.6. p.530-7.
Reviewed by Dr Bruce Adlam
Review: See 22-464.

Sports and Sports Medicine

22-466 Tendon healing: can it be optimised?

Maffulli N, Moller HD, Evans CH. Br J Sports Med. 1 October 2002. Vol.36. No.5. p.315-6.
Reviewed by Dr Chris Milne
Review: Tendon healing is a mixture of intrinsic and extrinsic healing. In extrinsic healing, which predominates early on, specialised fibroblasts move into the defect and synthesise collagen, which becomes progressively orientated along the direction of force through the tendon. In tendinopathic and ruptured Achilles tendons, there is an increase in type 3 collagen, which exhibits reduced tensile strength compared with type 1 collagen which predominates in normal tendons.
Comment: Useful article for those who deal with lots of tendon injuries. It describes the possible therapeutic future use of growth factors by gene.

22-467 Urine nandrolone metabolites: false positive doping test?

Kohler RM, Lambert MI. Br J Sports Med. 1 October 2002. Vol.36. No.5. p.325-9.
Reviewed by Dr Chris Milne
Review: Nandrolone has been much in the news in recent years, as many athletes have tested positive for it. Nandrolone is produced endogenously as an intermediate in the aromatisation of androgen to oestrogen. Intense exercise may increase its concentration in the urine. There is a need to develop laboratory methods that accurately distinguish endogenous from exogenous nandrolone metabolites.
Comment: This article gives some possible reasons for the spate of positive tests in recent years, but 'supplement' use is probably still responsible for most of the positive tests.

22-468 What advice should we give to athletes postconcussion?

McCrory P. Br J Sports Med. 1 October 2002. Vol.36. No.5. p.316-8.
Reviewed by Dr Chris Milne
Review: This practical article describes the key features of early assessment of concussion, relevant questions to assess recent memory, plus indications for urgent referral (e.g. development of focal signs or loss of consciousness for over five minutes). It advises giving a detailed (and preferably written) explanation of concussion and the normal symptoms to be expected, as the patient then knows what to expect, and the outcome is improved.
Comment: Useful practical article, should be read by any clinician who deals with concussed athletes. The best article about concussion for GPs that I have read in years.

22-469 Update on osteoarthritis part 1: current concepts and the relation to exercise.

Conaghan PG. Br J Sports Med. 1 October 2002. Vol.36. No.5. p.330-3.
Reviewed by Dr Chris Milne
Review: Joint injury appears to be the strongest predictor for later development of OA. High impact sports participants are at most risk. By contrast, there seems to be little risk associated with recreational running. Body mass index and occupation are further risk factors that should be considered.
Comment: Good news for recreational runners, bad news for thrill seekers. However, the management techniques for major joint injuries are improving all the time, which means that the injuries sustained by today's athletes should result in less degenerative change than those suffered by their predecessors.

22-470 Effects of stretching before and after exercising on muscle soreness and risk of injury: systematic review.

Herbert RD, Gabriel M. BMJ. 31 August 2002. Vol.325. No.7362. p.468-72.
Reviewed by Dr Len Brake
Review: It seemed a good idea and certainly had some posing appeal trying to look cool and not self-conscious with the stretching exercises. Like a Western version of Tai Chi.
Comment: In fact there is no benefit of reduction of muscle pain and no reduction of muscle injury. Oh dear. Too bad. Never mind.

Surgery

22-471 Suturing versus conservative management of lacerations of the hand: randomised controlled trial.

Quinn J, Cummings S, Callaham M, et al. BMJ. 10 August 2002. Vol.325. No.7359. p.299-301.
Reviewed by Dr Len Brake
Review: This is a randomised controlled trial comparing clinical outcomes in hand wounds less than 2cm and uncomplicated, between those closed with sutures and those treated conservatively. The mean time to resume normal activities was the same in both groups, cosmetic and functional outcomes at three months was the same. The non-sutured group, of course, also had less pain and less treatment time.

22-472 Tissue adhesive works as well as suturing.

Easton BT. J Fam Pract. June 2002. Vol.51. No.6. p.517.
Reviewed by Dr Bruce Adlam

Review: This multicenter randomised controlled trial indicates:- The tissue adhesive octylcyanoacrylate (Dermabond) is as effective as standard wound closure (sutures, staples, and tape adhesives) in repairing small uncomplicated lacerations and incisions (those that would normally be amenable to 5-0 suture) and does not lead to an increased rate of infection or dehiscence. (Original article reviewed: Surgery 2002; 131: 270-6).
Comment: Optimal cosmetic appearances at three months were no different for either treatment method.

Therapeutics

22-473 The therapeutic potential of stem cells from adults.

Kuehnle I, Goodell MA. BMJ. 17 August 2002. Vol.325. No.7360. p.372-6.
Reviewed by Dr Len Brake

Review: This clinical review is a good update. Items of interest: Adult stem cells such as haematopoietic stem cells have the ability to 'transdifferentiate' into other tissues. They have a previously unsuspected 'plasticity'. Cardiac muscle, liver, endothelial cells have been generated from whole bone marrow. The stem cells are easy to isolate and donor tolerance can be induced.
Comment: The aim is to use these cells therapeutically in patients with degenerative disorders of the liver, heart or brain.

Travel Medicine

22-474 Travel medicine: recent developments.

Zuckerman JN. BMJ. 3 August 2002. Vol.325. No.7358. p.260-4.
Reviewed by Dr Len Brake

Review: This is a concise update on the latest in travel related health problems and vaccinations. Malaria prevention is well presented as is rapid schedule vaccination. For those looking for detail, there is a list of references including pertinent websites.

Instructions for authors
New Zealand Family Physician publishes original papers on General Practice and family medicine. We encourage editorials, case reports and invite readers to contribute to regular features.

Manuscripts
Manuscripts may be submitted in printed or electronic format, preferably the latter. If possible the article should be submitted on a 3.5 inch disk in Word format, or emailed to the address below as an attachment. Where possible use standard fonts (such as Arial or Times) and keep formatting to a minimum. Please send a covering letter signed by all authors stating that the manuscript is original, has been read and approved and that no part of it has been submitted for publication elsewhere. We ask that the manuscript is no longer than 2500 words and that the style conforms to that detailed in "Uniform requirements for manuscripts submitted to biomedical journals" (New Zealand Medical Journal 1988, 101:200-204). Submit three clear copies, double spaced, wide margins and with numbered pages. Display on a separate title page the title of the paper, author's name (first name, initial, surname) and degrees; up to three key words; a brief curriculum vitae (about two sentences) for each author, name and address of author to whom communications should be sent; acknowledgments of grants. Begin the text with an abstract of less than 150 words. Abbreviations should be kept to a minimum. Use SI units throughout. Photographs of authors are welcome and should ideally be provided in digital (jpg) format.

References
Refer to published material by inserting numbers serially in the text. List no more than 20 references on the last page in the order cited in the text. Abbreviate journal names in the style of Index Medicus, and refer to journal articles as follows: authors' surnames and initials, title of article, abbreviated name of journal, year, volume number, first and last page numbers. Refer to books as follows: authors, title of chapter, title of book, edition, publishing house and city, year, page numbers referred to. Check the accuracy of every reference.

Illustrations
Graphs, charts and line drawings should be clean, sharp, black on white and of high standard of reproduction. Photographs must be of a professional standard, must show clear detail, and should ideally be submitted in digital (jpg) format.

Publishing dates
New Zealand Family Physician is published six times annually, in February, April, June, August, October and December. Original papers are submitted to referees before being accepted for publication, and are published as soon as space permits.

Subscriptions
The journal is provided free to all members of the RNZCGP. Rates for others are $90 per year within New Zealand, $80 plus $18 postage outside New Zealand. The Royal New Zealand College of General Practitioners, P O Box 10440, Wellington, New Zealand.

Editor
Dr Tony Townsend MGP (Otago) BSc FRNZCGP Dip Obst.

Editorial Board
Dr Bruce Arroll, Dr Andrew Divett, Professor Tony Dowell, Dr Pam Hyde, Dr Marjan Kljakovic, Dr Lynette Murdoch, Mr Andrew Stenson, Dr Jocelyn Tracey.

Emeritus Editors
Professor Campbell Murdoch, Dr Ian St George, Dr Tessa Turnbull, Dr Rae West.

Management Committee
Lee Sheppard, Hugh Sutherland.

Designer
Robyn Atwood

Advertising enquiries:
Colin Gestro ph: 09-449 2500, fax: 09-449 2552, email: colingestro@affinityads.com

All other correspondence to:
Lee Sheppard, Publications Administrator
Royal New Zealand College of General Practitioners
P O Box 10-440, WELLINGTON
Email: nzfp@rnzcgp.org.nz

The New Zealand Family Physician is the official journal of the RNZCGP, however, views expressed are not necessarily those of the College, the editor, or the editorial board.

The Royal New Zealand College of General Practitioners