Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Acta Obstet Gynecol Scand*
Am Fam Physician*
Ann Emerg Med*
Aust Fam Physician*
BMJ*
Brain Res*
Drug Alcohol Rev*
Evidence-Based Medicine*
Int J Obes*
Intern Med J*
J Bone Joint Surg Br*
J Fam Pract*
J Subst Abuse Treat*
Lancet*
Pharmacol Biochem Behav*
Prim Care*
*Journals indexed in Medline

Acupuncture

24–416 Treating drug using prison inmates with auricular acupuncture: a randomized controlled trial.

Berman AH, Lundberg U, Krook AL, et al. J Subst Abuse Treat. March 2004. Vol.26. No.2. p.95-102.

Reviewed by Dr Alex Chan

Review: This study tested whether ear acupuncture could reduce the psychological and physical discomfort and drug use in 158 Swedish prison inmates. The NADA-Acudetox protocol (Shen Men, Sympathetic, Kidney, Liver, Lung) administered in 14 sessions over four weeks was compared with a non-specific helix control protocol in this randomised trial. Participants in both groups reported reduced symptoms of discomfort and improved night time sleep. Ear acupuncture treatment was associated with total abstinence from drug use in the helix group and 73% abstinence in the NADA group.

Comment: The ear helix is not an inert area when needled. It has been used for conditions associated with inflammation, fever, allergies, and segment-related painful syndromes.

24–417 Acupuncture relieves pelvic and low-back pain in late pregnancy.

Kvorning N, Holmberg C, Grennert L, et al. Acta Obstet Gynecol Scand. 2004. Vol.83. No.3. p.246-50.

Reviewed by Dr Alex Chan

Review: The analgesic effect and possible adverse effects of acupuncture for pelvic and low-back pain during the last trimester of pregnancy were evaluated in 72 pregnant women in this randomised study. Control patients were not given sham acupuncture. Pain intensity was monitored by using the visual analogue scale (VAS). Simple traditional acupuncture points and local tender points were used in the study. During the study, VAS scores decreased in 60% of acupuncture patients compared with 14% of controls, and at the end of the study, 43% of the acupuncture patients were less bothered by pain during activities compared with 9% of controls. No serious side effects were recorded.

Comment: It is interesting to note that after approximately 12 months, one of the participating maternity ward centres could no longer include new patients, as rumours of successful acupuncture treatment during the study period had made further potential participants unwilling to accept the risk of being randomised to the control group.

24–418 A parametric study of electroacupuncture on persistent hyperalgesia and Fos protein expression in rats.

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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.

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Dennis Kerins, Goodfellow Unit
Faculty of Medical & Health Sciences
University Private Bag 92019
Auckland, New Zealand

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Lao L, Zhang R-X, Zhang G, et al. Brain Res. 10 September 2004. Vol.1020. No.1-2. p.18-29.
Reviewed by Dr Alex Chan

Review: Hyperalgesia in rats with induced chronic inflammation was assessed by paw withdrawal latency (PWL) to a noxious thermal stimulus. Electroacupuncture (EA) at 10- and 100-Hz at a current intensity of 3 mA was found to produce the greatest analgesic effects when compared to other parameters. Duration of 20-minutes stimulation was also found to be superior to either 10- or 30-minutes stimulation. Stimulation of GB30 also had greater analgesic effects than Waiguan (TE5) and other sham points, confirming acupoint specificity. Fos expression in the medial half of laminae I-II of the spinal cord where nociceptive primary afferents from the hind paw terminate was suppressed by EA.

Comment: Healthy and pathological conditions might respond to acupuncture differently. This study used a model of rats with chronic inflammation which is more relevant to daily practice. The findings indicate that there are optimal parameters of stimulation including frequencies, duration and acupoints specificity.

24-419 Electroacupuncture combined with indomethacin enhances antihyperalgesia in inflammatory rats.

Zhang R-X, Lao L, Wang X, et al. Pharmacol Biochem Behav. August 2004. Vol.78. No.4. p.793-7.
Reviewed by Dr Alex Chan

Review: In this study, the effect of combinations of electroacupuncture (EA) and low doses of indomethacin on inflammatory hyperalgesia and oedema was investigated in a rat model of inflammatory pain. Both 10 Hz and 100 Hz EA combined with low dose indomethacin had significant analgesic effect, but only the 10 Hz and indomethacin combination significantly reduced inflammatory oedema.

Comment: Electroacupuncture may be used to reduce the dosage of NSAIDs required for anti-inflammatory effects, and thus reduces the side effects associated with NSAIDs.

Adolescent Health

24-420 Restricted fetal growth and adverse maternal psychosocial and socioeconomic conditions as risk factors for suicidal behaviour of offspring: a cohort study.

Mittendorfer-Rutz E, Rasmussen F, Wasserman D. Lancet. 25 September 2004. Vol.364. No.9440. p.1135-40.
Reviewed by Dr Tony Hanne

Review: Over 700 000 young people in Sweden were followed up for 20 years to assess some of the risk factors for completed and attempted suicide. The rates of suicide were more than doubled among those who became teenage mothers, were low birth weight babies, and themselves had teenage mothers. To a lesser extent rates were still high if their mothers had a low educational level, if they were fourth or later in a family, and had short length at birth. The possible roles of inadequate antenatal nutrition on brain development and of social factors are discussed.

Comment: Just what is cause and what is effect is hard to determine but there can be no argument about the extent to which poor social circumstances are associated with a greatly magnified suicidal risk. If we want to change New Zealand's high youth suicide rate we are going to have to take social conditions among young people seriously by a commitment to improve these factors long before our adolescent patients start to present with warning signs.

Alcohol and Substance Abuse

24-421 Health status of clients receiving methadone maintenance treatment using the SF-36 health survey questionnaire.

Deering DE, Frampton CM, Horn J, et al. Drug Alcohol Rev. September 2004. Vol.23. No.3. p.273-80.
Reviewed by Dr Helen Moriarty

Review: Although patients on methadone maintenance rate their general health as good, when measured on SF-36 and compared to NZ norms (published in 1999) they did not fare as well as they think, or say they do, on health status. These clients were at the Christchurch hospital-based case load, and GP clients might differ (in unknown ways) from these participants.

Comment: GPs managing patients on methadone should be alert to and supporting of routine monitoring of the health needs of these clients, and able to guide them into preventative and treatment interventions as needed.

24-422 A review of drug use and driving: epidemiology, impairment, risk factors and risk perceptions.

Kelly E, Darke S, Ross J. Drug Alcohol Rev. September 2004. Vol.23. No.3. p.319-44.
Reviewed by Dr Helen Moriarty

Review: Alcohol problems and drunk driving are well described. This paper focuses on the 25% of accident-involved drivers who test positive for drugs; cannabis, benzos, cocaine, amphetamines and opioids. The paper concludes that drug-driving is a significant problem and one where public policy does not match the public danger.

Comment: In NZ drivers are tested routinely only for alcohol. Should we as GPs push for changes here: e.g. at least to test urines for cannabis. And if we did, how would that positive test be interpreted?

24-423 Three regimens for alcohol withdrawal and detoxification.

Asplund CA, Aaronson JW, Aaronson HE. J Fam Pract. July 2004. Vol.53. No.7. p.545-54.
Reviewed by Dr Bruce Adlam

Review: Quite good article with the following practice recommendations: (1) Patients with mild to moderate alcohol withdrawal symptoms and no serious psychiatric or medical comorbidities can be safely treated in the outpatient setting (SOR: A). (2) Patients with moderate withdrawal should re-

ceive pharmacotherapy to treat their symptoms and reduce their risk of seizures and delirium tremens during outpatient detoxification (SOR: A). (3) Benzodiazepines are the treatment of choice for alcohol withdrawal (SOR: A). (4) In healthy individuals with mild-to-moderate alcohol withdrawal, carbamazepine has many advantages making it a first-line treatment for properly selected patients (SOR: A).

Alcohol Drinking

24–424 Fourteen to seventeen-year-olds' experience of 'risky' drinking – a cross-sectional survey undertaken in south-east England.

Coleman LM, Cater S. Drug Alcohol Rev. September 2004. Vol.23. No.3. p.351-3.
Reviewed by Dr Helen Moriarty

Review: A quantitative study that puts 14 to 17-year-olds through an Adolescent Alcohol Expectancy Questionnaire. The findings were not too unexpected; binge drinking is common and occurs unsupervised, and is potentially harmful because it frequently extends to the point of getting very drunk.

Comment: NZ has the same phenomenon – but it does extend well into the 20s here. Safety when intoxicated is a major consideration, and one with ramifications for sexual health, psychological and physical harm. Where are the 'harm reduction' policies in NZ for this youth behaviour?

24–425 Human rights, drinking rights? Alcohol policy and indigenous Australians.

Martin D, Brady M. Lancet. 2 October 2004. Vol.364. No.9441. p.1282-3.
Reviewed by Dr Tony Hanne

Review: No-one seriously disputes the magnitude of problem drinking among Aboriginal communities where the average adult consumption is three times the agreed safe level. The argument is about why and what to do. In former more paternalistic days, prohibition operated in predominantly indigenous communities. The removal of bans on alcohol sales were seen as a matter of human rights being given, and the right to drink equated by some with the granting of citizenship. Responsibility has in recent years been given to local Aboriginal-controlled Community Councils who were charged with limiting damage from alcohol. They were placed in a hopelessly contradictory position by having to derive most of their income from alcohol sales.

Comment: It is easy for us to feel smug in New Zealand under the illusion that we have done much better by Maori. We also need to reconsider whether we have missed something important by holding up human rights as a supreme value without teaching about responsibility.

Asthma

24–426 A coughing child: could it be asthma?

Fardy HJ. Aust Fam Physician. May 2004. Vol.33. No.5. p.312-5.
Reviewed by Dr Barry Suckling

Review: Cough as the sole symptom of asthma is unusual. There is usually associated wheeze and shortness of breath. A family or personal history of atopic symptoms lend weight to the possibility of asthma. In children with asthma, physical examination and spirometry may be normal between episodes. In some cases where asthma is suspected, a trial of bronchodilation with formal assessment of response may be appropriate.

Comment: A good review.

Cardiovascular System

24–427 Long-term management of patients with unstable angina and non-ST-elevation MI.

Banas JS. J Fam Pract. June 2004. Vol.53. No.6. p.451-5.
Reviewed by Dr Bruce Adlam

Review: In the long-term care of patients with acute coronary syndrome, recently published studies show that prognostic benefits improve with more aggressive antiplatelet therapy for those at high risk for recurrent events. Moreover, long-term care should include aggressive LDL cholesterol-lowering therapy and use of beta-blockers and angiotensin-converting enzyme (ACE) inhibitors, in addition to diet modification and exercise. Immediately upon presentation of non-ST-elevation myocardial infarction (NSTEMI), aspirin therapy (81-325 mg) should be initiated (A). If aspirin is contraindicated, clopidogrel (300-mg loading dose followed by 75 mg/d) should be administered (A). In patients for whom an early noninterventional approach is planned, or for patients not at high risk of bleeding for whom percutaneous coronary intervention (PCI) is

planned, clopidogrel 75mg (once daily) should be added to aspirin therapy as quickly as possible and continued for up to nine months (B). Aggressive low-density lipoprotein (LDL) cholesterol-lowering therapy and general cardiovascular risk reduction are important in long-term management of these patients. Thus, a fibrate or niacin should be administered if the high-density lipoprotein (HDL) cholesterol is <40 mg/dL (B). In patients with LDL cholesterol >100 mg/dL, HMG-CoA reductase inhibitors (statins) and diet should be started during admission and continued after discharge (B).

24–428 Candesartan reduced mortality and hospital admissions in chronic heart failure.

Pitt B. Evidence-Based Medicine. March/April 2004. Vol.9. No.2. p.44-5.

Reviewed by Dr Bruce Arroll

Review: There were essentially four studies here with one adding candesartan to an ACE, one replacing an ACE when there were adverse effects to the ACE, and one where the ventricular ejection fraction was preserved. All found a benefit apart from the preserved group (borderline significance) NNT ranged from 46 for all cause mortality to 11 for composite endpoints. (Original articles reviewed: Lancet 2003; 362: 759-66. 767-71. 772-6. 777-81).

Comment: This suggests it is worth adding an angiotensin 2 blocker to an ACE and that there are benefits when given in place of an ACE and when the ejection fraction is preserved.

24–429 Effects of white and red wine on endothelial function in subjects with coronary artery disease.

Whelan AP, Sutherland WH, McCormick MP, et al. Intern Med J. May 2004. Vol.34. No.5. p.224-8.

Reviewed by Dr Helen Moriarty

Review: Red and white wine were compared in a cross-over study that looked at endothelial function, lipid profile, plasma alcohol and polyphenols (thought to be the red wine protective factor) before, one hour and six hours after wine with a light meal. Endothelial function improved after both red and white wine.

Comment: The study had a lot of limitations, and the link from better endothelial function to lower risk of coronary heart disease is not established – but I thought you would all be intrigued, anyway!

24–430 British Hypertension Society guidelines (BHS–IV)

Anonymous. J Fam Pract. July 2004. Vol.53. No.7. p.528, 30.

Reviewed by Dr Bruce Adlam

Review: This has probably been reported previously, however, the British Hypertension Society guidelines (BHS-IV) and the American Joint National Committee guidelines (JNC-7) are very similar in treatment goals. However, the BHS-IV guidelines do not require treatment until both the systolic and diastolic numbers are greater than 160/100 mm Hg, respectively, for patients without cardiovascular disease, diabetes, or other organ damage, whereas the JNC-7 guidelines start drug treatment in all patients with both numbers greater than 140/90 mm Hg. The BHS-IV suggests initial treatment with any one of four drugs (see the ABCD rule in the synopsis), whereas the bedrock of treatment recommended by the JNC-7 is diuretics, primarily because of the lower cost. (LOE=5). (Original article reviewed: BMJ 2004; 328: 634-40).

Comment: The guidelines recommend suggesting lifestyle modification for patients with high normal blood pressure, defined as a 130–139/85–89 mm Hg (strength of recommendation [SOR]=A).

Cerebrovascular System

24–431 Is an outpatient workup safe for patients with a transient ischemic attack?

Neher JO. J Fam Pract. July 2004. Vol.53. No.7. p.567-9.

Reviewed by Dr Bruce Adlam

Review: There is no compelling evidence that outpatient diagnostic workup of patients with transient ischemic attack (TIA) is less safe than inpatient workup, or that hospitalisation prevents stroke or improves stroke outcomes after TIA (SOR: C).

Comment: Because the risk of stroke is substantial in the week following a TIA, evaluation and treatment for reversible stroke risk factors should be initiated urgently and completed within a week of initial presentation (SOR: C, based on expert consensus opinion).

Communicable Diseases, Infections and Parasites

24–432 The causes and diagnosis of influenza–like illness.

Kelly H, Birch C. Aust Fam Physician. May 2004. Vol.33. No.5. p.305-9.

Reviewed by Dr Barry Suckling

Review: Influenza-like illnesses (ILI) are caused by influenza viruses, respiratory syncytial virus, rhinovirus, adenoviruses, parainfluenza viruses, and human corona viruses. Causes of atypical pneumonia include mycoplasma, Chlamydia and legionella, and may present with ILI symptoms. Polymerase chain reaction assays are now often used to diagnose ILI. With good sample collection (nose and throat swab) and transport to the laboratory, results may be available within 24 hours.

Comment: In some states in Australia, support by GPs for ILI surveillance to identify the early stages of an influenza pandemic, attracts CME points. Many GPs report that participation in ILI surveillance leads to an improvement in their recognition and management of patients with ILI.

24–433 Pertussis: presentation, investigation and management.

Frydenberg A, Starr M. Aust Fam Physician. May 2004. Vol.33. No.5. p.317-9.

Reviewed by Dr Barry Suckling

Review: Maternal antibody does not confer protection to the infant, so ba-

bies are particularly at risk of infection and complications until they have completed the primary course of vaccinations at six weeks, three months and five months. Diagnosis is mainly clinical, but can be confirmed with immunofluorescence on nasopharyngeal aspirate or nasal swab.
Comment: A good refresher.

Diagnosis

24-434 A three item screening instrument had moderate sensitivity and specificity for detecting migraine headaches.

Chessman AW. Evidence-Based Medicine. March/April 2004. Vol.9. No.2. p.56.
Reviewed by Dr Bruce Arroll
Review: There were three questions about migraine. They were: (1) Do you feel nauseated or sick to your stomach? (2) Did your headache limit you from working, studying or doing what you needed to do for any day in the previous three months? (3) Does light bother you a lot more than when you don't have headaches? A positive test is when there are two or more positive responses. Likelihood ratio of 3.3 and a likelihood ratio of 0.25 for a negative test. (Original article reviewed: Neurology 2003; 61: 375-82)
Comment: A reasonable test if you think the patient may have a migraine.

24-435 The problem with sensitivity and specificity.

Gallagher EJ. Ann Emerg Med. August 2003. Vol.42. No.2. p.298-303.
Reviewed by Dr Mike Slatter
Review: This editorial/review article looks at the way in which performance characteristics of diagnostic tests are expressed. It examines the concepts of sensitivity, specificity, positive and negative predictive values, receiver operating characteristics (ROC) curves and likelihood ratios (positive, negative and interval). The problem with sensitivity/specificity is that they are conceptually counterintuitive and predictive values are unstable.
Comment: This is a very straightforward simple explanation of these concepts. Likelihood ratios (LRs) make the most sense in the application of diagnostic tests to the revision of disease probability. LRs offer a far more clinically useful approach to diagnostic testing than sensitivity, specificity, predictive values and ROC curves. (See also 24-436).

24-436 Interval likelihood ratios: another advantage for the evidence-based diagnostician.

Brown MD, Reeves MJ. Ann Emerg Med. August 2003. Vol.42. No.2. p.292-7.
Reviewed by Dr Mike Slatter
Review: See 24-435.

Ear, Nose and Throat

24-437 Management of acute nasal fractures.

Kucik CJ, Clenney T, Phelan J. Am Fam Physician. 1 October 2004. Vol.70. No.7. p.1315-20.
Reviewed by Dr Len Brake
Review: The reminder to avoid focusing solely on the obvious trauma is once again helpful. A substantial blow in say a MVA or assault can be associated with cervical spine injury. A decent examination of the nasal airways needs a good light and some vaso-constrictor and analgesia. Plain XR is rarely indicated in uncomplicated fractures.
Comment: A good update on this common injury.

24-438 Cephalosporins better for streptococcus infections in children.

Anonymous. J Fam Pract. July 2004. Vol.53. No.7. p.526, 28.
Reviewed by Dr Bruce Adlam
Review: Treating streptococcal tonsillopharyngitis in children with a cephalosporin instead of penicillin produces significantly more bacteriologic and clinical cures. One additional child will benefit for every 13 children treated with a cephalosporin rather than penicillin. Only the cephalosporins cefaclor (Ceclor) and loracarbef (Lorabid) did not show an advantage over penicillin. The effect of cephalosporin treatment on prevention of rheumatic heart disease is not known. (LOE=1a). (Original article reviewed: Pediatrics 2004; 113: 866-82).
Comment: This study comparison was for a 10 day course of treatment. I'd be interested in seeing a review on the need for a 10 day course of treatment.

24-439 Tinnitus: Questions to reveal the cause, answers to provide relief.

Folmer RL, Martin WH, Shi Y. J Fam Pract. July 2004. Vol.53. No.7. p.532-40.
Reviewed by Dr Bruce Adlam
Review: Quite a good approach that provides recommendations where no treatable cause of tinnitus is found. It suggests we look at secondary problems (such as depression, anxiety, and insomnia), and implement tinnitus management strategies (SOR: B).

Emergency Medicine

24-440 Decision making in pediatric minor head trauma.

Greenes DS. Ann Emerg Med. October 2003. Vol.42. No.4. p.515-8.
Reviewed by Dr Mike Slatter
Review: This editorial looks at the development of two clinical decision rules for paediatric minor head trauma. Clinical variables such as headache, dizziness, amnesia and decreased verbal fluency cannot be used to evaluate very young children. The author finds that there are shortcomings with both the decision rules studied and advises caution in using these rules for detecting traumatic brain injury in children with minor head injuries.
Comment: Clinical decision rules for paediatric minor head injuries are not as well developed as those for adults. Important clinical variables in considering a CT scan include loss of consciousness, amnesia, headache, vomiting, drug and alcohol intoxication, trauma above the clavicles, scalp haematoma and

clinical signs of skull fracture. (See also 24-441 and 24-442).

24-441 A decision rule for identifying children at low risk for brain injuries after blunt head trauma.
Palchak MJ, Holmes JF, Vance CW, et al. Ann Emerg Med. October 2003. Vol.42. No.4. p.492-506.
Reviewed by Dr Mike Slatter
Review: See 24-440 and 24-442.

24-442 Prediction of intracranial injury in children aged five years and older with loss of consciousness after minor head injury due to nontrivial mechanisms.
Haydel MJ, Shembekar AD. Ann Emerg Med. October 2003. Vol.42. No.4. p.507-14.
Reviewed by Dr Mike Slatter
Review: See 24-440 and 24-441.

24-443 The Canadian C-Spine rule performs better than unstructured physician judgment.
Bandiera G, Stiell IG, Wells GA, et al. Ann Emerg Med. September 2003. Vol.42. No.3. p.395-402.
Reviewed by Dr Mike Slatter
Review: This study compares the predictive accuracy of emergency physicians' unstructured clinical judgement to the Canadian C-Spine rule. The Canadian C-Spine decision rule applies to alert stable adult patients with a Glasgow Coma Score of 15 and trauma to the head and neck. This clinical decision rule was better at detecting clinically important C-Spine injuries compared with unstructured clinical judgement and had a sensitivity of 100%.
Comment: This is a useful clinical tool when deciding on the need for X-rays in cases of trauma to the head and neck. We need to use this decision rule which has been well tested and where there are high stakes associated with a missed diagnosis. (See also 24-444).

24-444 The intrinsic fallibility of clinical judgment.
Gallagher EJ. Ann Emerg Med. September 2003. Vol.42. No.3. p.403-4.
Reviewed by Dr Mike Slatter
Review: See 24-443.

Endocrinology

24-445 Thyroid disease.
Evans TC. Prim Care. December 2003. Vol.30. No.4. p.625-40.
Reviewed by Dr M Hewitt
Review: Evaluation and treatment of thyroid excess and deficiency states are discussed. The use of TSH levels for monitoring the effectiveness of treatment regimes is recommended.
Comment: A nice summary with clear explanations, and a pathophysiological review.

24-446 Management of dyslipidemias in the age of statins.
Green ML. Prim Care. December 2003. Vol.30. No.4. p.641-69.
Reviewed by Dr M Hewitt
Review: A good summary of current evidence-based practice for the effectiveness of lipid lowering treatment. Analysis of the various types of statins available and case studies to illustrate the 'best fit'. This then enables the primary care physician to do 'best practice'.
Comment: Unfortunately in New Zealand Pharmac knows best, and funding constraints affect doctor and consumer choice.

24-447 Postmenopausal hormone therapy: a concise guide to therapeutic uses, formulations, risks, and alternatives.
Mitchell JL, Walsh J, Wang-Cheng R, et al. Prim Care. December 2003. Vol.30. No.4. p.671-96.
Reviewed by Dr M Hewitt
Review: This article provides a good analysis and summary of the current best evidence-based knowledge for HRT. In particular, regard is paid to overall risks versus benefits.
Comment: A topical review and despite recent adverse publicity for HRT, HRT properly used and appropriately prescribed has much to offer women.

24-448 Polycystic ovary syndrome: a review for primary providers.
Buccola JM, Reynolds EE. Prim Care. December 2003. Vol.30. No.4. p.697-710.
Reviewed by Dr M Hewitt
Review: Clinical presentation of period irregularly with features of excessive male hormone should alert the clinician to the possibility of polycystic ovary syndrome. Other risk factors are taken into account and considered with regard to the 'whole package'.
Comment: It is important to recognise this condition early so management and treatment can more effectively reduce the risk this condition presents.

24-449 Osteoporosis management in the new millennium.
Wei GS, Jackson JL, Hatzigeorgiou C, et al. Prim Care. December 2003. Vol.30. No.4. p.711-41.
Reviewed by Dr M Hewitt
Review: With greater numbers of ageing women the overall long-term risks of osteoporosis are significant. The authors adequately cover the clinical management and best practice recommendations, using evidence-based medicine and National Osteoporosis Foundation Guidelines.
Comment: Oestrogen may be preferred for the newly menopausal including the option of Raloxifene. This is a selective oestrogen receptor modulator without the apparent risks of oestrogen. For older women calcium, exercise and vitamin D and alendronate feature as the recommended therapies.

24-450 Male hypogonadism in the primary care clinic.
Grant NN, Anawalt BD. Prim Care. December 2003. Vol.30. No.4. p.743-63.
Reviewed by Dr M Hewitt
Review: This condition is not well recognised in clinical practice. There is a good clinical description with common practice presentations and some practical advice on how to avoid errors in biochemical diagnosis.
Comment: Having made the diagnosis, then the question of risk management arises. Care in diagnosis and prescribing for athletes is required.

24-451 Diagnosis and management of pituitary tumors: recent advances.

Pickett CA. Prim Care. December 2003. Vol.30. No.4. p.765-89.
Reviewed by Dr M Hewitt
Review: A good summary of what is currently available in the way of medical treatment for prolactinomas and growth-hormone adenomas. There appears to be not much improvement in the treatment options available for gonadotropin or non-secreting tumours.
Comment: An important read for doctors interested in sports medicine, as these synthetic analogues are at the cutting edge for athletes to improve performance and recovery.

24-452 Issues in the diagnosis of Cushing's syndrome for the primary care physician.

Schuff KG. Prim Care. December 2003. Vol.30. No.4. p.791-9.
Reviewed by Dr M Hewitt
Review: The author looks at the common presenting features of Cushing's disease and discusses why the diagnosis is not always made with accuracy. She outlines tests and procedures which she recommends to facilitate the diagnostic process.
Comment: The syndrome has many overlapping features with other common conditions. A review of the clinical features aligned with effective tests will improve diagnostic accuracy.

24-453 Hyperaldosteronism and pheochromocytoma: new tricks and tests.

Failor RA, Capell PT. Prim Care. December 2003. Vol.30. No.4. p.801-20.
Reviewed by Dr M Hewitt
Review: This was a previously considered rare cause of hypertension and often overlooked in primary care presentations of hypertension. The authors consider the incidence much higher than previously thought and recommend the renin-aldosterone ratio as the best initial screening test.
Comment: Given the recent advanced pharmacological agents such as ACE-inhibitors then consideration of this primary aetiology for hypertension is important.

24-454 Strategies to reduce complications of type 2 diabetes.

Ullom-Minnich P. J Fam Pract. May 2004. Vol.53. No.3. p.366-74.
Reviewed by Dr Bruce Adlam
Review: See 24-455.

24-455 Treating type 2 diabetes: targeting the causative factors.

Sutherland JE, Hoehns JD. J Fam Pract. May 2004. Vol.53. No.5. p.376-88.
Reviewed by Dr Bruce Adlam
Review: These two articles (see 24-454) look at moves to improve care for diabetics in primary care.
Comment: There is nothing new in these and worth perhaps only a cursory glance by those implementing current programmes.

24-456 Starting insulin in type 2 diabetes: continue oral hypoglycemic agents? A randomized trial in primary care.

Goudswaard AN, Stolk RP, Zuithoff P, et al. J Fam Pract. May 2004. Vol.53. No.5. p.393-9.
Reviewed by Dr Bruce Adlam
Review: Quite a nice study, although small, supporting the addition of bedtime NPH insulin to maximal oral therapy – a simple, safe, and well-tolerated regimen that lowers HbA1c on average by one percentage point.
Comment: Expect this regimen to fail for about 25% of patients within one year.

24-457 What is the best treatment for diabetic neuropathy?

Newton WP, Collins L. J Fam Pract. May 2004. Vol.53. No.5. p.403-8.
Reviewed by Dr Bruce Adlam
Review: Tricyclic antidepressants, anticonvulsants, and capsaicin reduce the pain of diabetic neuropathy; limited data suggests that lidocaine patches may also be efficacious. Both tricyclic antidepressants and anticonvulsants are superior to placebo in relieving painful diabetic neuropathy. Compared with placebo, patients taking tricyclic antidepressants report reduced pain (number needed to treat [NNT] for at least 50% reduction=3.5) (strength of recommendation [SOR]: A). Similarly, patients taking anticonvulsants report reduced pain (NNT for at least 50% reduction in pain=2.7) (SOR: A).

Gastroenterology

24-458 Topical capsaicin cream was effective for chronic idiopathic intractable pruritis ani.

Gutknecht DR, Evidence-Based Medicine. May/June 2004. Vol.9. No.3. p.86.
Reviewed by Dr Bruce Arroll
Review: This group of patients had intractable pruritis ani for more than three months and got improvement with topical capsaicin. The dose used was 0.006% which is a quarter of the dose of zostrix (available in NZ) hence it may pay to dilute with a cream base in a ratio of 4:1. (Original article reviewed: Gut 2003; 52: 1323-6).
Comment: Worth trying when all else fails. The number needed to treat to get a benefit may be less than two treated to get one person better.

24-459 Nonalcoholic fatty liver disease: is all the fat bad?

Clouston AD, Powell EE. Intern Med J. April 2004. Vol.34. No.4. p.187-91.
Reviewed by Dr Helen Moriarty
Review: A review article, this collates the various patterns of fatty liver disease and relates it to disease progression. Covers the natural history and aetiology and management. Bottom line: steatosis alone is benign but hepatocyte injuries will lead to cirrhosis.
Comment: A useful reference paper. Fatty liver is common in NZ amongst a variety of identifiable risk groups.

Geriatrics

24-460 Assessment and management of falls in older people.

Hill K, Schwarz J. Intern Med J. September 2004. Vol.34. No.9-10. p.557-64.
Reviewed by Dr Helen Moriarty
Review: This paper reviews known evidence for effectiveness of falls prevention. It discusses the role of a comprehensive falls risk factor as-

sessment and who should have that. It makes a call for research into gaps in knowledge and for more trials in hospital settings.
Comment: Hey, what about primary care in all of this – surely we are the ones who see a 'faller' first?

Gynaecology

24-461 No long-term benefit shown for bones after HRT.

J Fam Pract. June 2004. Vol.53. No.6. p.444, 447.
Reviewed by Dr Bruce Adlam
Review: Women taking short-term hormone replacement therapy (HRT) for symptom relief cannot expect long-term bone protection. Hip fracture risk is at least as great for women who stop postmenopausal hormone therapy as that for women who have never used it. The loss of protection occurs within five years of cessation of treatment. (LOE=1b) (Original article reviewed: Obstet Gynecol 2004; 103: 440-6.)

24-462 Useful signs and symptoms to evaluate vaginal complaints.

J Fam Pract. June 2004. Vol.53. No.6. p.448, 450.
Reviewed by Dr Bruce Adlam
Review: Clinical question – How useful are the history, physical examination, and routine office-based laboratory studies in the diagnosis of vaginitis? (Original article reviewed: JAMA 2004; 291:1368-79).
Comment: Bottom line – In the diagnosis of vaginitis, useful symptoms include information about itching. Useful signs include odour and the presence of inflammatory changes. Office microscopy is the most accurate laboratory test. (LOE=3a).

24-463 Oral iron therapy reduced unexplained fatigue in non-anaemic women with serum ferritin concentrations <50 ug/l.

Becker LA. Evidence-Based Medicine. March/April 2004. Vol.9. No.2. p.47.
Reviewed by Dr Bruce Arroll
Review: This was a trial in women with fatigue who were non anaemic and had serum ferritin concentrations <50 micrograms/l. They were given long acting iron 80mg/day for four weeks. At the end of four weeks there was an improvement in their fatigue. (Original article reviewed: BMJ 2003; 326: 1124-7)
Comment: Although there was a benefit it is not clear how effective this treatment was as the numbers needed to treat could not be calculated.

Health Services

24-464 Voices lost: indigenous health and human rights in Australia.

Anderson I, Loff B. Lancet. 2 October 2004. Vol.364. No.9441. p.1281-2.
Reviewed by Dr Tony Hanne
Review: Health statistics for Aboriginal people are worse than in many developing countries. Both men and women live on average 20 years less than European Australians. Their death rate between 35–54 years is five times the rest of the population. Of great significance from a general practice point of view is that hospitals spend twice as much on Aboriginal patients but only one-third per head is spent on their primary care. The article's authors from Monash University are strongly critical of the loss of any opportunity under recent governments for the indigenous people to have any real control of their own health care.
Comment: There is obviously a strong political message intended for an Australian audience just before their recent election. There is also a useful message for New Zealand health authorities. We do better – but not much! There is also clear confirmation of worldwide research which shows that a strong primary care system usually equals better outcomes in almost every way.

Musculoskeletal System

24-465 Back pain – clinical assessment.

Jensen S. Aust Fam Physician. June 2004. Vol.33. No.6. p.393-401.
Reviewed by Dr Barry Suckling
Review: This article presents a simple examination designed with general practice in mind. It is based on a 'look, move, feel' approach. Exclusion of 'red flags' and identification of 'yellow flags' are important.
Comment: A good safe simple approach. (For the complete series on back pain in this issue, see 24-465, 24-466, 24-467, 24-468, 24-469, 24-470 and 24-471).

24-466 Acute low back pain: assessment and management.

Wilk V. Aust Fam Physician. June 2004. Vol.33. No.6. p.403-7.
Reviewed by Dr Barry Suckling
Review: A specific cause of low back pain need not be established for appropriate management to be instituted, with the involvement of the patient as partner. We need to take patient's previous experience, personal preferences, and cultural factors in to account when recommending therapy.
Comment: A good balanced review. (For the complete series on back pain in this issue, see 24-465, 24-466, 24-467, 24-468, 24-469, 24-470 and 24-471).

24-467 Lumbar radicular pain.

Govind J. Aust Fam Physician. June 2004. Vol.33. No.6. p.409-12.
Reviewed by Dr Barry Suckling
Review: Radicular pain is caused by irritation of the dorsal root ganglion of a spinal nerve. It is more than just a mass effect: it is a combination of compression sensitizing the nerve root to mechanical stimulation, and stretching, with a chemically mediated inflammatory reaction.
Comment: Though most cases settle with simple analgesics, lasting pain relief can be achieved with epidural steroid injection. (For the complete series on back pain in this issue, see 24-465, 24-466, 24-467, 24-468, 24-469, 24-470 and 24-471).

24-468 Diagnostic imaging for back pain.

Yelland M. Aust Fam Physician. June 2004. Vol.33. No.6. p.415-9.
Reviewed by Dr Barry Suckling

Review: X-rays make no difference to outcomes for back pain and related disability. For the exclusion of serious causes of back pain, the accuracy of X-rays and CT scans is limited. Most positive findings on radiological investigations, particularly degenerative findings, have little association with back pain. A history that includes the key features of serious causes will detect all patients requiring imaging. It is important to explain this to patients, to reassure them about the absence of serious causes, and to put incidental findings into perspective.

Comment: It may be useful to use the essence of this article to inform patients who wish imaging. It has been shown that a brief educational intervention (see Patient Education review on Back Pain - 24-471) can reduce the proportion of patients who believe X-rays are necessary, from 73% to 44%, without affecting patient satisfaction, or missing any serious pathology. (For the complete series on back pain in this issue, see 24-465, 24-466, 24-467, 24-468, 24-469, 24-470 and 24-471).

24-469 Back pain rehabilitation.

Thomas CH, MacAdams D. Aust Fam Physician. June 2004. Vol.33. No.6. p.427-30.
Reviewed by Dr Barry Suckling

Review: Back pain becomes chronic in 5-10% of patients. This article outlines the paradigms that GPs can adopt to assist their patients to live with persistent back pain. Rehabilitation, when used early, can improve function and assist in return to work. (For the complete series on back pain in this issue, see 24-465, 24-466, 24-467, 24-468, 24-469, 24-470 and 24-471).

24-470 Back pain and opioid seeking behaviour.

Sim MG, Hulse G, Khong E. Aust Fam Physician. June 2004. Vol.33. No.6. p.431-5.
Reviewed by Dr Barry Suckling

Review: This case study provides a practical approach to dealing with patients with chronic pain who are suspected of opioid dependence.

Comment: A good framework for managing pain and dependence. (For the complete series on back pain in this issue, see 24-465, 24-466, 24-467, 24-468, 24-469, 24-470 and 24-471).

24-471 Patient education: low back pain.

Wilk V. Aust Fam Physician. June 2004. Vol.33. No.6. p.436.
Reviewed by Dr Barry Suckling

Review: A good one page Patient Information Sheet advising on home management of low back pain, and on the limitations of X-rays in defining the specific cause.

Comment: A balanced approach. Worth using. (For the complete series on back pain in this issue, see 24-465, 24-466, 24-467, 24-468, 24-469, 24-470 and 24-471).

24-472 Repetitive strain injuries: has the Australian epidemic burnt out?

Awerbuch M. Intern Med J. July 2004. Vol.34. No.7. p.416-9.
Reviewed by Dr Helen Moriarty

Review: A discussion paper. Australia (as did NZ) had an 'epidemic' of RSI in the 1980s. The history of this phenomenon is discussed from the perspective of a pain management unit doctor. Similar events occurred in NZ - renaming the phenomenon, distancing it from occupational injury, challenging the disease as an entity, in the absence of evidence of tissue damage, etc.

Comment: It talks of an 'obituary' as if the condition has now gone forever. In NZ it has become less visible, mainly due to changes in ACC claim rules. Thought provoking.

Nutrition

24-473 Parental overweight, socioeconomic status and high birth weight are the major determinants of overweight and obesity in 5-7 y-old children: baseline data of the Kiel Obesity Prevention Study (KOPS)

Danielzik S, Czerwinski-Mast M, Langnase K, et al. Int J Obes. November 2004. Vol.28. No.11. p.1494-502.
Reviewed by Dr Anne-Thea McGill

Review: This study shows that in multivariate analyses parental overweight, a low SES as well as a high birth weight were the strongest independent risk factors of overweight and obesity in children. Additionally, there were sex-specific risk factors: parental smoking and single households were risk factors in boys, whereas a low activity was associated with obesity in girls. The prevalence of obesity reached 29.2% in boys and 33.4% in girls with all the three main risk factors. This study reports cross sectional questionnaire data from 2600 parents of the same number of children of a well planned cohort study. It is being done in Germany.

Comment: Although this study is reported parental data, it uses validated questionnaires and thorough methods, and the authors have clearly discussed and diagrammed corrections for limitations. The authors covered the area of childhood obesity well and compared their results with other studies. It used a good sample base. This is an important study for New Zealand as what appears as self evident information has rarely been actually shown in this sort of analysis. Although data can not necessarily be extrapolated to New Zealand (though other ethnicities were included in this study) New Zealand is showing the same serious child-onset obesity trends as most other Westernised countries. Particularly, large babies are common in New Zealand and it is not only small for dates babies who are at risk for obesity.

Oncology

24-474 Olfactory detection of human bladder cancer by dogs: proof of principle study.

Willis CM, Church SM, Guest CM, et al. BMJ. 25 September 2004. Vol.329. No.7468.

p.712 (6 pages)
Reviewed by Dr Len Brake
Review: Anecdotal claims that dogs may be able to detect malignant tumours arose from one woman's experience of her dog taking a persisting interest in a lesion on her skin which subsequently proved to be a malignant melanoma. This was reported in Lancet in 1989. Tumours do produce volatile organic compounds, which are released into the atmosphere. Here, dogs were trained to discriminate between urine from normal patients and patients with bladder cancer.
Comment: Successful detection of urine samples from patients with bladder cancer was achieved 41% of the time (as against a 14% result from chance alone). This gives the lie to Dorothy Parker's epigram - "You can't teach an old dogma new tricks".

24-475 Lung cancer.

Mitchell G, Mitchell C. Aust Fam Physician. May 2004. Vol.33. No.5. p.321-5.
Reviewed by Dr Barry Suckling
Review: Outlines the role of the GP in the diagnosis, treatment and palliative care of the patient with lung cancer.
Comment: A good review.

24-476 Antioxidant supplements for prevention of gastrointestinal cancers: a systematic review and meta-analysis.

Bjelakovic G, Nikolova D, Simonetti RG, et al. Lancet. 2 October 2004. Vol.364. No.9441. p.1219-28.
Reviewed by Dr Tony Hanne
Review: The theoretical protective effect of antioxidants against gastrointestinal cancers including cancers of the pancreas and liver led some to assume that if some antioxidants in the diet were beneficial, a lot more by way of supplements would be even better. 14 trials of generally high quality among over 170,000 subjects failed to show any benefit in cancer prevention from any vitamin supplement. There is the possibility of a marginal benefit from selenium but much greater numbers would be needed. What was alarming was that among the highest quality trials there was actually a significantly greater mortality among supplement users.
Comment: It is highly unlikely that the news media and therefore the general public will take any notice of this very substantial evidence but at least as GPs we can give our patients the good news, all that supplements produce is expensive urine!

Orthopaedics

24-477 Does injection of steroids and lidocaine in the shoulder relieve bursitis?

Gutierrez G, Burroughs M. J Fam Pract. June 2004. Vol.53. No.6. p.488-90, 492.
Reviewed by Dr Bruce Adlam
Review: Subacromial steroid injection may provide a small, short-term benefit compared with placebo. The short-term effectiveness of steroid injection compared with nonsteroidal anti-inflammatory agents (NSAIDs) remains unclear. Steroid injections are better than physiotherapy alone in the short term. However, injection does not appear to provide any meaningful long-term benefit compared with other therapies (strength of recommendation: B).
Comment: Data are insufficient to make recommendations regarding the proper timing of injection in the sequence of other treatments. Side effects of steroid injection, such as steroid flare and infection, are rare.

24-478 Ultrasound in the diagnosis of fractures in children.

Hubner U, Schlicht W, Outzen S, et al. J Bone Joint Surg Br. November 2004. Vol.82-B. No.8. p.1170-3.
Reviewed by Dr Len Brake
Review: Simple fractures should be well within the range of primary care treatment. The problem being easy access to radiology without patients having to cart films all over town. Within the next 5 years ultrasound equipment is as likely to be part of the GP's arsenal as the ECG is now.

This study found good correlation with X-ray findings in children with long bone fractures. US was most reliable for detection of simple femoral and humeral diaphyseal fractures and fractures of the forearm. Several type of fracture gave such reliable information that XR was not required.
Comment: Could this be a way?

Palliative Treatment

24-479 A good death down under.

Hardy JR, Vora R. Intern Med J. August 2004. Vol.34. No.8. p.450-2.
Reviewed by Dr Helen Moriarty
Review: A short discussion article about the use of pathways/guidelines for managing patients who are dying. Asks if there is a place for these in Australia.
Comment: What about NZ. Would we use a primary care guideline on end-of-life care?

Paediatrics

24-480 Should home apnea monitoring be recommended to prevent SIDS?

Shoemaker M, Ellis M, Meadows S. J Fam Pract. May 2004. Vol.53. No.5. p.418-9.
Reviewed by Dr Bruce Adlam

Review: While home apnoea monitoring may find an increased incidence of apnoea and bradycardia in preterm infants, compared with term infants, no association links these events with sudden infant death syndrome (SIDS). Apnoea of prematurity is not a proven risk factor for SIDS.
Comment: Since apnoea of prematurity has not been shown to be a precursor to SIDS, home apnoea monitoring for the purpose of preventing SIDS cannot be recommended (strength of recommendation [SOR]: B, based on a single prospective cohort study and multiple case-control studies). Neonates with significant neurologic or pulmonary disease may benefit from apnoea monitoring (SOR: C, expert opinion).

Psychiatry and Psychology

24-481 Interpersonal counselling in general practice.

Judd F, Weissman M, Davis J, et al. Aust Fam Physician. May 2004. Vol.33. No.5. p.332-7.
Reviewed by Dr Barry Suckling
Review: Interpersonal counselling (IPC) derives from interpersonal psychotherapy, but is briefer in the number and duration of sessions and is particularly suited to primary care.
Comment: IPC can be used in general practice to reduce psychological symptoms, restore morale, improve self esteem and the quality of the patient's interpersonal relationships.

24-482 Chronic illness and the experience of surviving cancer.

Little M. Intern Med J. April 2004. Vol.34. No.4. p.201-2.
Reviewed by Dr Helen Moriarty
Review: An interesting (and short) discussion paper about cancer survivors. 30% of cancer survivors suffer post cancer distress severe enough to interfere with their lives.
Comment: Raises interesting questions of how can we help/how should we help.

Research Design and Methodology

24-483 The power of power.

Blandino D, Rao G. J Fam Pract. July 2004. Vol.53. No.7. p.566.
Reviewed by Dr Bruce Adlam
Review: Another useful summary of power in study design.

Respiratory System

24-484 Data on treating bronchiolitis severely limited.

J Fam Pract. May 2004. Vol.53. No.5. p.353.
Reviewed by Dr Bruce Adlam
Review: In spite of the large number of studies assessing treatments for bronchiolitis, in general the studies have been small, of poor quality, and don't assess clinically important endpoints. The treatments may be effective, however, just unproven. To really judge their effectiveness the authors reported on 44 studies of the most commonly used agents: epinephrine, beta-2-agonist bronchodilators (albuterol and salbutamol), corticosteroids, and ribavirin. (Original article reviewed: Arch Pediatr Adolesc Med 2004; 158: 127-37)
Comment: They found a handful of studies evaluating inhaled helium, RSV-immunoglobulin, Chinese herbs, and so forth, but chose not to report these data in the paper. (If readers are interested, these are reported in an AHRQ Evidence Report at www.ahrq.gov/clinic/evrptfiles.htm#bronch).

24-485 Are beta-2-agonists or anticholinergics more effective for treating COPD?

Richmond JR, Babcock CF, Mayo HG. J Fam Pract. JUne 2004. Vol.53. No.6. p.494-6.
Reviewed by Dr Bruce Adlam
Review: Both b2-agonists and anticholinergics appear to improve symptoms for patients with chronic obstructive pulmonary disease (COPD). Recent research indicates that adding a long-acting anticholinergic to a b2-agonist may improve quality of life for patients with stable COPD more than the use of b2-agonists alone.

24-486 Lower respiratory tract infections and community acquired pneumonia in adults.

Stocks N, Turnidge J, Crockett A. Aust Fam Physician. May 2004. Vol.33. No.5. p.297-301.
Reviewed by Dr Barry Suckling
Review: Describes the aetiology, clinical assessment, investigations and management of acute bronchitis and CAP in the community.
Comment: With community acquired pneumonia, investigations such as C reactive protein, serology, and CXR are suggested. Uses a pneumonia severity index (PSI) to assess the need for hospitalisation.

Rheumatic Diseases

24-487 Do acetaminophen and an NSAID combined relieve osteoarthritis pain better than either alone?

Buescher JJ, Meadows S. J Fam Pract. June 2004. Vol.53. No.6. p.501-3.
Reviewed by Dr Bruce Adlam
Review: Combining nonsteroidal anti-inflammatory drugs and acetaminophen for short courses provides more relief of pain in osteoarthritis without an increase in side effects (strength of recommendation [SOR] = B). Combining acetaminophen at 4 g/d with an NSAID can also decrease the daily dose of NSAID required for pain relief, thus reducing the potential risk from higher-dose NSAID therapy (SOR=B).

Therapeutics

24-488 Randomised controlled trial of physiotherapy compared with advice for low back pain.

Frost H, Lamb SE, Doll HA, et al. BMJ. 25 September 2004. Vol.329. No.7468. p.708 (6 pages)
Reviewed by Dr Len Brake
Review: All guidelines suggest that patients keep active as part of management of low back pain. Some also advise spinal manipulation and most advise exercise therapy for chronic low back pain. Patients in this trial

had had back pain for over 6 weeks and had been referred to physiotherapy by their GP. There was a 'physiotherapy advice only' group and a 'standard physiotherapy' group.
Comment: The study shows routine physiotherapy for patients with mild low back pain is no more effective than advice given by the physiotherapist.

Urology

24–489 Clinical practice guidelines for chronic kidney disease in adults: Part II. Glomerular filtration rate, proteinuria, and other markers.

Johnson CA, Levey AS, Coresh J, et al. Am Fam Physician. 15 September 2004. Vol.70. No.6. p.1091–7.

Reviewed by Dr Len Brake

Review: This is a summation of National Kidney Foundation's set of guidelines for assessment of chronic kidney disease. In particular, information on assessment of proteinuria is clearly laid out.
Comment: A handy reference especially relating to those insurance company requests for further investigation of proteinuria.

Virus Diseases

24–490 Epstein-Barr virus infectious mononucleosis.

Ebell MH. Am Fam Physician. 1 October 2004. Vol.70. No.7. p.1279–87.

Reviewed by Dr Len Brake

Review: Always good to read a fact-packed up to date summary and this is just such a paper. A copy is now in our CME file. There are no surprises. There is a recommended diagnostic strategy which hopefully for most is a reassuring reminder rather than earth shattering. See Patient Information page attached.
Comment: If the patient has more than 20% atypical lymphocytes or more than 50% lymphocytes with at least 10% atypical lymphocytes, infectious mononucleosis is likely. Bed rest is unhelpful and acyclovir provides no benefit.

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Lee Sheppard, Publications Administrator
Royal New Zealand College of General Practitioners
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