Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Ann Intern Med*
Arch Phys Med Rehabil*
Aust Fam Physician*
Can Fam Physician Med Fam Can*
Drug Alcohol Rev*
Homeopathy*
Intern Med J*
J Fam Pract*
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Lancet*
New Zealand Journal of Sports Medicine
Obes Res*
Pediatrics*
Physician and Sportsmedicine*
Prim Care*
Sci Am*
*Journals indexed in Medline

Abnormalities

25–431 The primary care physician's approach to congenital anomalies.

Falk MJ, Robin NH. Prim Care. September 2004. Vol.31. No.3. p.605-19.
Reviewed by Dr M Hewitt

Review: The authors look at the whole area of congenital anomalies in children and document an approach to identify the pathogenesis of the birth defects. They include genetic testing to confirm and define the diagnosis. Once this is established, then an effective primary care management of the condition can be instituted.

25–432 Clinical consult: development delay/fragile X syndrome.

Wiesner GL, Cassidy SB, Grimes SJ, et al. Prim Care. September 2004. Vol.31. No.3. p.621-5.
Reviewed by Dr M Hewitt

Review: The authors present a case study of fragile X syndrome and illustrate the appropriate features from the genetics, through to the clinical presentation, diagnosis and on-going management.
Comment: A good review. The frequency is 1:4000 births for males and 1:800 for females.

25–433 Down syndrome, Turner syndrome, and Klinefelter syndrome: primary care throughout the life span.

Tyler C, Edman JC. Prim Care. September 2004. Vol.31. No.3. p.627-48.
Reviewed by Dr M Hewitt

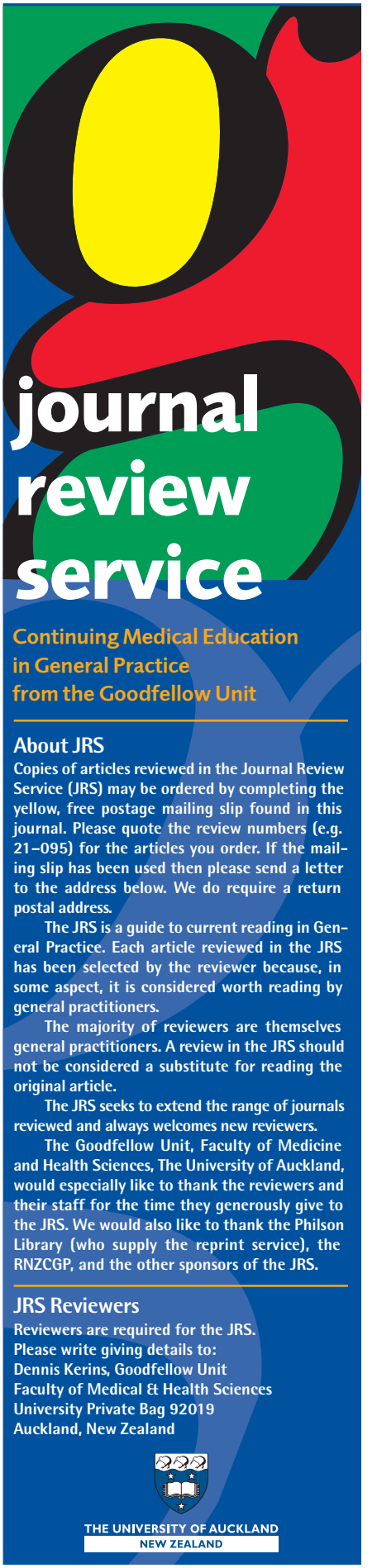
Review: These are the most well known of the common genetic abnormalities found in primary care. While Down Syndrome is diagnosed at birth, the other two conditions are recognised and diagnosed much less frequently. The authors include a thorough check list of the clinical features and what health risks they represent and how a primary care physician can best recognise and then manage these.

Acupuncture

25–434 The effect of real and sham acupuncture on thermal sensation and thermal pain thresholds.

Downs NM, Kirk K, MacSween A. Arch Phys Med Rehabil. June 2005. Vol.86. No.6. p.1252-7.
Reviewed by Dr Alex Chan

Review: This study investigated the effect of acupuncture (real or sham) and a control intervention on cold sensation, warm sensation, cold pain and hot pain thresholds on 18 healthy, acupuncture naive volun-



teers. A thermal sensory analyser both delivered the thermal stimuli and recorded the subjects' responses before and after the interventions which took place once a week over three weeks. Real and sham acupuncture were delivered via the Park sham needle carrier, except that for real acupuncture, real needles were used. A trend towards a decreased sensitivity to thermal pain and thermal sensation was observed with real acupuncture but it did not differ significantly from the changes with sham or control interventions.

Comment: This is a simple and straightforward experiment. However, the equivocal results could be because of the position of the thermode (which was placed over the thenar eminence) in relation to the acupuncture points used (which were TE 5 on the forearm and LI 11 on the elbow). If one asks any acupuncturist to make up a prescription for treating a condition in the thenar eminence, it would be very unlikely that the combination of TE5 and LI 11 acupoints will come up as the most common answer.

25–435 Manual acupuncture for analgesia during electromyography: a pilot study.

Smith MJ, Tong HC. Arch Phys Med Rehabil. September 2005. Vol.86. No.9. p.1741-4.
Reviewed by Dr Alex Chan

Review: This is a randomised, double-blinded (patient and assessor), controlled study of the analgesic effect of acupuncture on needle electromyography in 51 subjects. Either real acupuncture needles or telescopic sham needles were applied by one of two acupuncturists before the electromyography examination. Pre- and post- electromyography pain magnitudes were recorded using a 100-mm visual analogue scale. Change in pain levels in the treatment group was lower than in the control group but not statistically significant. However, post hoc analysis excluding five subjects treated by the novice acupuncturist (who was found to have inserted the needles improperly) showed a significant difference.

Comment: The study demonstrated that for studies in which interventions are to be performed by different people, the interventions have to be standardised and the performance observed and compared to make sure there are no inconsistencies before the study proper. Otherwise, the results might not be reliable.

25–436 Acupuncture in patients with osteoarthritis of the knee: a randomised trial.

Witt C, Brinkhaus B, Jena S, et al. Lancet. 9 July 2005. Vol.366. No.9480. p.136-43.
Reviewed by Dr Alex Chan

Review: Two hundred and ninety-four patients with radiologically proven osteoarthritis of the knee and with a pain intensity score of equal to or greater than 40/100 on a 100 mm visual analogue scale participated in this randomised controlled trial. Patients were divided into acupuncture, minimal acupuncture and waiting list groups. For the intervention groups, 12 sessions of 30 minutes acupuncture or minimal acupuncture were given over eight weeks. Western Ontario and McMaster Universities Osteoarthritis (WOMAC) index was used as the primary outcome measure plus a multitude of secondary measures. At week 8, the acupuncture group had significantly better results in measures such as pain, stiffness and physical functions comparing with the minimal acupuncture and waiting list groups. There was no significant difference between the acupuncture and minimal acupuncture groups at week 26 or 52. Since all waiting list patients received acupuncture after week 8, no long-term comparison could be obtained between the acupuncture and the non- intervention group. (See also 25-437).

Comment: A very high quality study with pre- published protocol, interventions designed by experienced medical acupuncturists, all main analysis by intention to treat, credible outcome measures, and very high follow-up rates. Well worth reading.

25–437 Acupuncture: not just needles?

Moore A, McQuay H. Lancet. 9 July 2005. Vol.366. No.9480. p.100-1.
Reviewed by Dr Alex Chan

Review: See 25-436.

Alcohol and Substance Abuse

25–438 'Cultural fraud': the role of culture in drug abuse.

Eckersley RM. Drug Alcohol Rev. March 2005. Vol.24. No.2. p.157-163.
Reviewed by Dr Helen Moriarty

Review: A philosophical paper that looks at drivers for drug and alcohol abuse and decries the focus on

culture as an 'excuse' for AOD use. It argues that marginality and disadvantage are a narrow focus that takes away the interest in understanding individual behaviours. Socio-cultural reasons are value-laden. An interest in resistance and capacity to change is more helpful for AOD problems.
Comment: I agree that any form of 'labelling' can be counterproductive. This paper highlights the concept of 'culture' as a community of interest – not necessarily skin deep.

25-439 Are cannabis users exposed to other drug use opportunities? Investigation of high-risk drug exposure opportunities among young cannabis users in London.
Strang J, McCambridge J. Drug Alcohol Rev. March 2005. Vol.24. No.2. p.185-91.
Reviewed by Dr Helen Moriarty
Review: The cannabis users were recruited from further education colleges across London. IVDU were excluded. Their association with alcohol, heroin and injecting drug use was studied by enquiry about use amongst their friends. Forty per cent of the 200 young people reported that friends 'hardly' ever used drugs other than cannabis. One in three respondents had been present during heroin smoking, one in eight present when associates were injecting drugs.
Comment: Does this mean that cannabis itself leads to other drug opportunities? Or is it the illicit nature of cannabis that places users in company of other drug users? Would decriminalising cannabis help or hinder other drug exposure opportunities?

Asthma

25-440 Difficult asthma in adults: recognition and approaches to management.
Harrison BD. Intern Med J. September 2005. Vol.35. No.9. p.543-7.
Reviewed by Dr Helen Moriarty
Review: A discussion paper on clinical perspectives. This highlights the importance of ascertaining if asthma symptoms are in fact due to asthma or to coexisting physical or psychological problems, including poor compliance. Difficult asthma is defined as a disconnection between expectations and outcome, and discordance between symptoms and lung function tests. COPD plus or minus bronchiectasis have been reported in up to 16% of 'resistant' asthma cases in OPD settings. In 12% the diagnosis may be some other condition.
Comment: A useful reminder to marry clinical signs and symptoms with outcomes and always be prepared to review the diagnosis, no matter how long established. This article also has a useful list of structured diagnostic management in difficult asthma.

Cardiovascular System

25-441 Abdominal aortic aneurysm screening recommended for some men.
Fleming C, Whitlock EP, Beil TL, et al. J Fam Pract. May 2005. Vol.54. No.5. p.408-9.
Reviewed by Dr Bruce Adlam
Review: The US Preventive Services Task Force practice guideline recommends a one-time screening for abdominal aortic aneurysm (AAA) by ultrasound in men aged 65 to 75 years who have ever smoked. They make no recommendation for men who haven't smoked and recommend against screening women. (Original article reviewed see 25-442, 25- 443 and 25-444).

25-442 Screening for abdominal aortic aneurysm: recommendation statement.
U.S. Preventive Services Task Force. Ann Intern Med. 1 February 2005. Vol.142. No.3. p.198-202.
Reviewed by Dr Bruce Adlam
Review: See 25-441, 25-443 and 25-444.

25-443 Screening for abdominal aortic aneurysm: a best-evidence systematic review for the U.S. Preventive Services Task Force.
Fleming C, Whitlock EP, Beil TP, et al. Ann Intern Med. 1 Feburary 2005. Vol.142. No.3. p.203-11.
Reviewed by Dr Bruce Adlam
Review: See 25-441, 25-442 and 25-444.

25-444 Screening for abdominal aortic aneurysm: recommendations from the U.S. Preventive Services Task Force – summaries for patients.
U.S Preventive Services Task Force. Ann Intern Med. 1 February 2005. Vol.142. No.3. p.I-52.
Reviewed by Dr Bruce Adlam
Review: See 25-441, 25-442 and 25-443.

25-445 Do beta-blockers worsen respiratory status for patients with COPD?
Baselli LM, Oswald MA, Nashelsky JM. J Fam Pract. May 2005. Vol.54. No.5. p.472-3.
Reviewed by Dr Bruce Adlam
Review: Evidence-based answer: Based on a high-quality meta-analysis of controlled trials, patients with chronic obstructive pulmonary disease (COPD) who use cardioselective beta-blockers (beta1-blockers) do not experience a significant worsening of their short-term pulmonary status as measured by changes in forced expiratory volume in one second (FEV1), or by changes in patients' self-reported symptoms. If such harmful effects do exist, they are likely to be less clinically important than the substantial proven benefits of beta-blockade for patients with concomitant cardiovascular disease (strength of recommendation: A)
Comment: Despite the implied strength of these studies, most GPs can recall patients with unexplained change in respiratory status on beta-blockers. We would still be inclined to start low and closely monitor respiratory status.

25-446 Prevention of cardiovascular events with an antihypertensive regimen of amlodipine adding perindopril as required versus

atenolol adding bendroflumethiazide as required, in the Anglo-Scandinavian Cardiac Outcomes Trial-Blood Pressure Lowering Arm (ASCOT-BPLA): multicentre randomised controlled trial.

Dahlof B, Sever PS, Poulter NR, et al. Lancet. 10 September 2005. Vol.366. No.9489. p.895-906.

Reviewed by Dr Tony Hanne

Review: Nearly 20 000 patients with hypertension and multiple risk factors were randomised between two treatments looking particularly at non-fatal and fatal cardiac events, and strokes. The trial was stopped after 5.5 years because of a clear superiority of the amlodipine-perindopril regimen. Even more significant was a substantially lower incidence of diabetes in this group. Of interest in possibly explaining the difference was a higher HDL, and lower creatinine, triglycerides and BMI in the same group. Blood pressure lowering was virtually identical in both groups. (See also 25-447 and 25-448).

Comment: For years the experts have been telling us that beta-blockers and thiazides should be the first line treatment in hypertension. The patients on the other hand have mostly told us they felt better on calcium channel blockers and ACEs. The patients as usual seem to have been right.

25-447 Role of blood pressure and other variables in the differential cardiovascular event rates noted in the Anglo-Scandinavian Cardiac Outcomes Trial-Blood Pressure Lowering Arm (ASOT-BPLA)

Poulter NR, Wedel H, Dahlof B, et al. Lancet. 10 September 2005. Vol.366. No.9489. p.907-13.

Reviewed by Dr Tony Hanne

Review: See 25-446 and 25-448.

25-448 Evidence that new antihypertensives are superior to older drugs.

Staessen JA, Birkenhager WH. Lancet. 10 September 2005. Vol.366. No.9489. p.869-71.

Reviewed by Dr Tony Hanne

Review: See 25-446 and 25-447.

25-449 Chronic heart failure: optimising care in general practice.

Piterman L, Zimmet H, Krum H, et al. Aust Fam Physician. July 2005. Vol.34. No.7. p.547-53.

Reviewed by Dr Rachel Monk

Review: Heart failure is a major problem in developed countries and despite good evidence and guidelines, management is not always optimal. As well as general measures and medication, patient education is essential in care of all patients with heart failure.

Comment: www.heartfoundation.com.au has useful patient education resources.

25-450 Giant cell arteritis: presenting as stroke, transient ischaemic attack and dementia.

Morris OC, Lockie P. Aust Fam Physician. August 2005. Vol.34. No.8. p.653-5.

Reviewed by Dr Rachel Monk

Review: Single case study illustrating the role giant cell arteritis can play in strokes and dementia.

25-451 Use of a quantitative point-of-care test for the detection of serum cardiac troponin T in patients with suspected acute coronary syndromes.

Hallani H, Leung DY, Newland E, et al. Intern Med J. September 2005. Vol.35. No.9. p.560-2.

Reviewed by Dr Helen Moriarty

Review: A new point-of-care trop. T test was compared with a gold standard assay on 133 patients presenting to hospital with possible cardiac chest pain. The test was falsely negative in six of 24 patients with a positive lab test.

Comment: Clearly there would be advantages in having a rapid near-patient diagnostic test for trop. T, but this particular product is not sensitive enough – and reliance on it would lead to missed diagnoses. Hopefully the next generation P.O.C test for trop. T will prove more reliable. A reliable P.O.C test could be a boon for rural practices and EM settings.

25-452 Impact of candesartan on nonfatal myocardial infarction and cardiovascular death in patients with heart failure.

Demers CD, McMurray JV, Swedberg K, et al. JAMA. 12 October 2005. Vol.294. No.14. p.1794-8.

Reviewed by Dr Raina Elley

Review: This randomised placebo controlled trial demonstrates that angiotensin II receptor blockers are effective in reducing the combined outcome of cardiovascular death or non-fatal MI. (20.4% of the intervention group had one or other of these outcomes vs 22.9% of the control group; hazard ratio 0.87 (95% CI 0.79-0.96) and an NNT of 40). In the study, 7599 patients with CHF were followed up for a median of 37.7 months and allocated to have candesarten or placebo in addition to their usual cardiovascular medication.

Comment: The study appears to be of good design with appropriate primary composite outcome, study size and duration. It will be reassuring to know that angiotensin II receptor blockers confer similar cardioprotection to that of ACE inhibitors in patients with congestive heart failure, as this has not been shown before. The fact that sudden death or fatal MI and hospitalisation for unstable angina or revascularisation did not reduce significantly, does not detract from the other positive findings, as the outcome numbers were low, in the first case, and other factors, such as physician practice influencing the decision to perform surgery will have a subjective influence on the outcome in the latter case. This was acknowledged in the paper.

Cerebrovascular System

25-453 Management of carotid artery stenosis: update for family physicians.

Louridas G, Junaid A. Can Fam Physician Med Fam Can. July 2005. Vol.51. p.984-989.

Reviewed by Dr Mike Lyons

Review: Two recent randomised controlled trials support a more aggressive approach to referral for carotid

endarterectomy (CEA) in patients with T.I.A.s. Patients with hemispheric symptoms associated with a >70% stenosis of the internal carotid artery need urgent referral for consideration of surgery. Patients with 50–69% stenosis may benefit from surgery depending on associated comorbidity and clinical features. Patients with stenosis less than 50% do not benefit from surgery. Asymptomatic patients with stenosis greater than 60% should be referred for elective CEA. Risk reduction from various forms of medical management is briefly summarised. Acceptable risks associated with CEA are tabled.
Comment: A more aggressive approach is endorsed by these surgeons. They also suggest that as 35% of patients with a carotid bruit have a stenosis >50%, carotid artery auscultation should be part of the routine physical examination in the general adult population and all patients found to have a murmur be referred for a duplex scan.

25–454 Preventing recurrent ischemic stroke: a 3-step plan to prevent recurrent stroke, address the patient's risk factors, clear stenosis, and thin the blood.
Cohen SN. J Fam Pract. May 2005. Vol.54. No.5. p.412-22.
Reviewed by Dr Bruce Adlam
Review: This is a nicely written article with good tables and the following recommendations: (a) Once a stroke patient has stabilised, if there is no contraindication, consider starting an antihypertensive agent regardless of the baseline blood pressure. (b) For symptomatic patients with high-grade carotid stenosis (70% to 99%), plan a course of medical management plus carotid endarterectomy (CEA). With moderate carotid stenosis (50% to 69%), CEA offers only moderate stroke risk reduction. (c) When aspirin is the antiplatelet drug of choice, it is reasonable to use daily doses between 50mg and 325mg.
Comment: Worthwhile item with three messages: control risk factors, clear stenosis and 'thin' the blood. PHOs may be interested in linking some of these recommendations into their disease management programmes.

Communicable Diseases, Infections and Parasites

25–455 The growing threat of avian influenza.
Henley E. J Fam Pract. May 2005. Vol.54. No.5. p.442-4.
Reviewed by Dr Bruce Adlam
Review: This item gives a factually correct background to avian flu. The risk assessment has changed somewhat since it was written as avian to human cases have now occurred in five Asian countries and the spread of bird deaths is spreading westwards towards Europe.
Comment: Largest risk of avian to human illness to Australia and New Zealand will occur in spring as migratory birds return to the southern hemisphere. Australia's risk is higher as shorter migrations of duck species return from Indonesia, although I'm told the odd duck does get blown NZ's way. Migratory birds (godwits and oystercatchers) have a more eastward migration over the sea and this may afford some protection.

25–456 Incidence of adamantane resistance among influenza A (H3N2) viruses isolated worldwide from 1994 to 2005: a cause for concern.
Bright RA, Medina M, Xu X, et al. Lancet. 1 October 2005. Vol.366. No.9492. p.1175-81.
Reviewed by Dr Tony Hanne
Review: Over 7000 viruses submitted to the WHO Centre at the CDC, Atlanta from around the world between 1994 and 2005 were tested for resistance to anti-viral agents. A rapid rise in resistance to amantadine and rimantadine in the last few years was detected particularly in strains from Southeast Asia. Of special concern was the finding that all isolates of H5N1, the avian influenza, were resistant. Suggested reasons for this trend include inappropriate use, too easy access and possibly use in the poultry industry. (See also 25-457 and 25- 458).
Comment: Given our experience with the development of bacterial antibiotic resistance these results should be no surprise. This study also gives major concern about the folly of heavy reliance on anti-virals in the event of a pandemic of avian influenza.

25–457 Efficacy and effectiveness of influenza vaccines in elderly people: a systematic review.
Jefferson T, Rivetti D, Rivetti A, et al. Lancet. 1 October 2005. Vol.366. No.9492. p.1165-74.
Reviewed by Dr Tony Hanne
Review: See 25-456 and 25-458.

25–458 Resistance to anti-influenza agents.
Guan Y, Chen H. Lancet. 1 October 2005. Vol.366. No.9492. p.1139.
Reviewed by Dr Tony Hanne
Review: See 25-456 and 25-457.

Dermatology

25–459 Topical therapies for psoriasis: evidence-based review.
Afifi T, de Gannes G, Huang C, et al. Can Fam Physician Med Fam Can. April 2005. Vol.51. p.519-25.
Reviewed by Dr Tim Kenealy
Review: A useful summary. New to me was the evidence of effectiveness of combined therapies with corticosteroid plus vitamin D analogues (e.g. Diavonex) and corticosteroids plus retinoids (although the only mentioned retinoid is not available in New Zealand).

25–460 Acneiform facial eruptions: a problem for young women.
Cheung MJ, Taher M, Lauzon GJ. Can Fam Physician Med Fam Can. April 2005. Vol.51. p.527-33.
Reviewed by Dr Tim Kenealy
Review: A useful reminder with pictures, that everything that looks like acne may not be acne. Discusses di-

agnosis and treatment of acne vulgaris, rosacea, folliculitis and perioral dermatitis.

25–461 What is angular cheilitis and how is it treated?

Skinner N, Junker JA, Flake D. J Fam Pract. May 2005. Vol.54. p.470-1.

Reviewed by Dr Bruce Adlam

Review: Evidence-based answer: Cheilitis is a broad term that describes inflammation of the lip surface characterized by dry scaling and fissuring. Specific types are atopic, angular, granulomatous, and actinic. Angular cheilitis is commonly seen in GP settings as an inflammation, scaling and fissuring that radiates from the corners of the mouth. Evidence reveals that topical ointment preparations of nystatin or amphotericin B treat angular cheilitis (strength of recommendation: A)

Comment: There is some evidence for improving oral health through regular use of xylitol or xylitol/chlorhexidine acetate containing chewing gums to decrease angular cheilitis in nursing home patients. A recipe for chaos more likely.

25–462 Managing skin cancer: 23 golden rules.

Dixon AJ, Hall RS. Aust Fam Physician. August 2005. Vol.34. No.8. p.669-71.

Reviewed by Dr Rachel Monk

Review: Great little article with 23 useful tips when it comes to dealing with skin cancers.

Diabetes

25–463 Diabetes, exercise, and foot care: minimizing risks in patients who have neuropathy.

Ward SA. Physician and Sportsmedicine. August 2005. Vol.33. No.8. p.33-8.

Reviewed by Dr Rob Campbell

Review: This paper is focused on diabetics who have neuropathy but are keen to exercise. Sensible advice on foot care, footwear care and appropriate exercise is given. It also includes a patient handout.

Comment: A good practical paper to help avoid foot ulcers and infections in the diabetic patient.

Diagnosis

25–464 Diagnosing headache.

Joubert J. Aust Fam Physician. August 2005. Vol.34. No.8. p.621-5.

Reviewed by Dr Rachel Monk

Review: This article looks at diagnosis of headache; initially by distinguishing between primary and secondary headache. The author then reviews the typical features of common primary headaches.

Comment: I must admit I didn't find this system of classification very helpful but it may work well for some people.

25–465 Migraine: diagnosis and treatment.

Joubert J. Aust Fam Physician. August 2005. Vol.34. No.8. p.627-32.

Reviewed by Dr Rachel Monk

Review: Sometimes migraine can be a frustrating problem to treat. I found this a very useful article.

Comment: Well worth a read for every GP.

25–466 Neck related causes of headache.

Jensen S. Aust Fam Physician. August 2005. Vol.34. No.8. p.635-9.

Reviewed by Dr Rachel Monk

Review: Not having much experience in musculoskeletal medicine I found this article very interesting. It may well explain some of those patients that don't seem to fit properly into the other typical headache groups and is likely to be much more prevalent than we acknowledge.

25–467 Atypical facial pain: a diagnostic challenge.

Quail G. Aust Fam Physician. August 2005. Vol.34. No.8. p.641-5.

Reviewed by Dr Rachel Monk

Review: The majority of cases of facial pain are clear cut but some are not. This very interesting article is illustrated by three case histories as examples of when all is not as it seems.

Emergency Medicine

25–468 'I can't breathe': assessment and emergency management of acute dyspnoea.

Thomas P. Aust Fam Physician. July 2005. Vol.34. No.7. p.523-9.

Reviewed by Dr Rachel Monk

Review: Number one important task in assessing a person with dyspnoea is a good history. ABC is also a vital starting point. This article, with case studies, is a good reminder of the process when you are faced with a breathless patient.

25–469 Management of an acute asthma attack.

Barnard A. Aust Fam Physician. July 2005. Vol.34. No.7. p.531-4.

Reviewed by Dr Rachel Monk

Review: Despite improved prevention measures for asthma, an acute attack is not an uncommon emergency in general practice, so it's important to have a good grasp of management. This article recaps the appropriate management for both adults and children. (Erratum attached to article).

Comment: Nice table to help determine severity.

Ethics

25–470 End-of-life: a Catholic view.

Markwell H. Lancet. 24 September 2005. Vol.366. No.9491. p.1132-5.

Reviewed by Dr Tony Hanne

Review: This is one of a series of articles from different religious and philosophical perspectives on the issue of end-of-life and the caregiver. It deals with questions such as the dignity of human life and the interconnectedness of human society. It discusses what it calls a covenantal relationship between the doctor and the patient as something above the

mere contractual, and the impact this can have on trust and the meaning of informed consent. It faces the very important distinction between pain and suffering, and our responsibility towards each.
Comment: Whether we identify with the particular theological position of the writer or not, this article has a depth and sensitivity about the process of dying and what it should be with which GPs can identify. It is so far above just legal rights or cost-benefit analysis which is where most modern discussion seems to end.

25–471 From advance directives to advance care planning: current legal status, ethical rationales and a new research agenda.
Jordens C, Little M, Kerridge I, et al. Intern Med J. September 2005. Vol.35. No.9. p.563-6.
Reviewed by Dr Helen Moriarty
Review: An easy to read discussion paper about the potentially thorny area of advance directives. What if the patient made the directive decades ago? What if treatments are now available that will improve quality of life? What are the implications for the medical team if they inaccurately defer the advance directives and proceed with treatments?
Comment: Very worthwhile reading. This is something we do not often discuss with patients – why not?

Eye Diseases

25–472 Chronic open-angle glaucoma: review for primary care physicians.
Adatia FA, Damji KF. Can Fam Physician Med Fam Can. September 2005. Vol.51. No.9. p.1229-37.
Reviewed by Dr Mike Lyons
Review: These glaucoma specialists from the Ottawa Eye Institute state that mass screening for chronic open angle glaucoma (COAG) has unacceptably high rate of both false positive and false negative results. The argument for case finding is advanced. Risk factors include age (doubles every 10 years), black race, family history, myopia and intraocular pressure >22mm Hg. Level C evidence associates type 2 diabetes, hypertension, migraine and sleep apnea. An estimated 50% of cases are undetected. Examination of the optic nerve head is the mainstay of diagnosis with a sensitivity and specificity exceeding 90%. The authors suggest the best way for family physicians to detect cases is to refer at risk patients to an optometrist or opthalmologist. Measurement of intraocular pressure and visual fields are valuable – but over 50% off the nerve fibres could be lost by the time visual field defects are evident. The five classes of topical medications are tabled and side effects highlighted.
Comment: A good review article – if you don't have a stored favourite. How many GPs are confident detecting increased cup to disk ratio on fundoscopy? The free of charge referral of our diabetic patients to local optometrists for two yearly retinal screening has eased the referral of patients with glaucoma risks and opened a healthy collegial dialogue.

Gastroenterology

25–473 Stool antigen testing for the diagnosis and confirmation of eradication of Helicobacter pylori infection: a prospective blinded trial.
Islam S, Weilert F, Babington R, et al. Intern Med J. September 2005. Vol.35. No.9. p.526-9.
Reviewed by Dr Helen Moriarty
Review: A New Zealand study of stool testing for H.pylori conducted in Hamilton over 12 months, following 127 patients of whom 113 had a positive urease test, prebiopsy, and 112 confirmed on biopsy. The stool tests proved highly specific for H.pylori diagnosis compared to the combined 'gold' standards, and also for post-eradication testing.
Comment: Stool tests are cheaper and non-invasive compared to urease test or biopsy. It would put the management totally into the Primary Care domain. This paper is reassuring that a urease test or biopsy are not necessary if stool testing is available in your community.

General

25–474 Test-tube teeth.
Sharpe PT, Young CS. Sci Am. August 2005. Vol.293. No.2. p.34-41.
Reviewed by Dr Ron Vautier
Review: After reviewing how tooth development occurs naturally, this article goes on to describe progress in two broad approaches to making it happen in vitro. Either the appropriate cells are seeded on to a biodegradable scaffold, or the appropriate signals are applied to a collection of suitable stem cells.
Comment: Artificially created living teeth might be available sooner than some think, but perhaps not as soon as many of us hope for.

Genetics

25–475 Clinical application of genetic risk assessment strategies for coronary artery disease: genotypes, phenotypes, and family history.
Scheuner MT. Prim Care. September 2004. Vol.31. No.3. p.711-38.
Reviewed by Dr M Hewitt
Review: The author recognises that the pathogenesis of coronary artery disease is complex and multifactorial. Using a genetic risk assessment involving family histories goes some way to identifying those who are most at risk prior to onset of significant clinical manifestation.
Comment: Primary care and prevention is increasingly an exercise in modern risk management.

25–476 Genetics for targeting disease prevention: diabetes.

Newell AM. Prim Care. September 2004. Vol.31. No.3. p.743-66.
Reviewed by Dr M Hewitt
Review: A new look and overview of what is known about the inherited models of type I, type II and gestational diabetes mellitus. The author enables the reader to use information to predict at risk persons before significant clinical manifestations.
Comment: Brave, new world. Would that they would listen.

Gynaecology

25–477 Making sense of breast pathology.

Bilous M, Brennan M, French J et al. Aust Fam Physician. July 2005. Vol.34. No.7. p.581-6.
Reviewed by Dr Rachel Monk
Review: Ever felt you didn't really understand breast pathology reports? Want to know more?
Comment: You'll find this article not only helpful for your own learning but also for educating patients and deciding best management.

Hemic and Lymphatic Systems

25–478 Genetic thrombophilia.

Feero WG. Prim Care. September 2004. Vol.31. No.3. p.685-709.
Reviewed by Dr M Hewitt
Review: Coagulation disorders of genetic origin are an important cause of venous thrombosis. The author gives background information of the natural history and the genetics of these disorders. With analysis and predictive capacity, treatment plans for these are more precise and outcomes, previously unfavourable, have been improved.

Homeopathy

25–479 Pharmacoeconomic comparison between homeopathic and antibiotic treatment strategies in recurrent acute rhinopharyngitis in children.

Trichard M, Chaufferin G, Nicoloyannis N. Homeopathy. January 2005. Vol.94. No.1. p.3-9.
Reviewed by Dr Mimi Irwin
Review: This is a prospective pragmatic study of 499 children (18 months to five years) who were treated for recurrent acute rhinopharyngitis by either allopathic or homeopathic general practitioners in France. The study was supported by Laboratories Boiron. The number of episodes of acute recurrent rhinopharyngitis, complications, and the cost of treatment, as well as the amount of time off work taken by parents, were studied. Homeopathy was significantly more helpful than conventional therapy in the recurrence rate of rhinopharyngitis, number of complications and the quality of life scores. Parents with homeopathically treated offspring had significantly less sick leave even though more of the homeopathically treated children attended day care.
Comment: This is an interesting study. The cost differences between conventional treatment and homeopathic treatment were not large, however, the impact of less parental leave has economic significance. The other issue, of course, is the use of antibiotics in the treatment of rhinopharyngitis. This therapy may well have not been appropriate.

25–480 Adjunctive homeopathic treatment in patients with severe sepsis: a randomized, double-blind, placebo-controlled trial in an intensive care unit.

Frass M, Linkesch M, Banyai S, et al. Homeopathy. April 2005. Vol.94. No.2. p.75-80.
Reviewed by Dr Mimi Irwin
Review: The purpose of this Austrian randomised, double-blind, placebo-controlled study was to assess whether homeopathic treatment, in conjunction with conventional intensive care, had a positive influence on the long-term outcome of people with severe sepsis. Seventy patients were studied and 35 were assigned to either homeopathic treatment plus conventional or placebo plus conventional care. The survival rate at both 30 and 180 days was recorded. By day 30 there was a non-statistically significant trend to improved survival with homeopathic treatment. At 180 days, however, survival was significantly higher in the homeopathically treated group: verum 75.8% and placebo 50%.(P=0.043)
Comment: Homeopathy may be a useful additional treatment in patients with severe infection. There were no adverse effects with the homeopathic preparations and this treatment did not interfere with conventional care. It would be interesting if this study could be replicated and with larger numbers of participants.

25–481 Comparative efficacy of homeopathic and allopathic systems of medicine in the management of clinical mastitis of Indian dairy cows.

Varshney JP, Naresh R. Homeopathy. April 205. Vol.94. No.2. p.81-5.
Reviewed by Dr Mimi Irwin
Review: Mastitis in cows is an expensive problem for farmers to treat in developing countries. This study compared the efficacy of homeopathic treatment for mastitis with conventional antibiotic treatment. It also compared recovery time and treatment costs. Ninety-six mastitic quarters (fibrosed and non-fibrosed) were treated with a complex homeopathic product and the outcome was compared with 96 non-fibrosed mastitic quarters that were treated with antibiotics. The group of cows receiving homeopathic therapy took longer to recover, with 86% of the group reaching recovery in 7.7 days. The homeopathic treatment cost 21.4 Rupees. The cure rate for the antibiotic group was 59.2% but the recovery was quicker at 4.5 days. The cost of antibiotics was significantly higher than the homeopathic product and cost 149.20 Rupees. The milk of the cows treated with antibiotics also had to be discarded.

Comment: I was interested to see that the homeopathic treatment protocols showed a better response when the cows were dosed four times daily rather than twice daily. Achieving a cure took longer using homeopathy, however, homeopathic products were significantly cheaper than the antibiotic medication. It would be interesting to study the relapse rate in both groups to assess if there was any difference.

25–482 Effects of homeopathic treatment on salivary flow rate and subjective symptoms in patients with oral dryness: a randomized trial.

Haila S, Koskinen A, Tenovuo J. Homeopathy. July 2005. Vol.94. No.3. p.175-81.
Reviewed by Dr Mimi Irwin

Review: Xerostomia is a difficult condition to treat. Twenty-eight Finnish patients took part in a controlled longitudinal study of the effects of individualised homeopathic treatment on this troublesome problem. Salivary flow and symptoms of oral dryness were assessed. The experimental group receiving active homeopathic products experienced significant relief and there was no improvement in the placebo group. In fact after six weeks the placebo group was offered homeopathic treatment with good effect. VAS-scores were used to assess symptoms and mouth dryness and need to sip while eating both improved significantly. ($P<0.0001$) Patients with rheumatoid arthritis and Sjogren's also found they had improvements generally and not just restricted to their oral symptoms. This finding fits in with homeopathic theory. If homeopathic treatment is effective the presenting symptoms should improve as well as the overall well-being of the patient.
Comment: It would be worthwhile to repeat this study with more participants.

25–483 Homoeopathy and 'the growth of truth'

Vandenbroucke JP. Lancet. 27 August 2005. Vol.366. No.9487. p.691-2.
Reviewed by Dr Tony Hanne

Review: This is one of two articles in the same issue commenting on a study also in this issue (see 25-470) which analysed 110 placebo-controlled studies on homeopathic medicines compared with 110 on conventional medicine. While the conventional trials were far more convincing both as to methods and results, there still remains a public belief that there must be value in homeopathy because of bias among doctors and the pharmaceutical industry. Nothing has changed in 160 years since John Forbes in 1846 showed no difference between homoeopathic remedies and his own, presumably because he had nothing which worked other than opium and digitalis. (See also 25-484, 25-485 and 25-486).
Comment: The *Lancet* editorial adds these words, *'Now doctors need to be bold and honest with their patients about homeopathy's lack of benefit, and with themselves about the failings of modern medicine to address patients' needs for personalised care.'*

25–484 Are the clinical effects of homoeopathy placebo effects? Comparative study of placebo-controlled trials of homoeopathy and allopathy.

Shang A, Huwiler-Muntener K, Nartey L, et al. Lancet. 27 August 2005. Vol.366. No.9487. p.726-32.
Reviewed by Dr Tony Hanne

Review: See 25-483, 25-485 and 25-486.

25–485 The end of homoeopathy.

Lancet. 27 August 2005. Vol.366. No.9487. p.690.
Reviewed by Dr Tony Hanne

Review: See 25-483, 25-484 and 25-486.

25–486 Critics slam draft WHO report on homoeopathy.

McCarthy M. Lancet. 27 August 2005. Vol.366. No.9487. p.705-6.
Reviewed by Dr Tony Hanne

Review: See 25-483, 25-484 and 25-485.

Metabolic Diseases

25–487 Clinical consult: iron overload – hereditary hemochromatosis.

Matthews AL, Grimes SJ, Wiesner GL, et al. Prim Care. September 2004. Vol.31. No.3. p.767-70.
Reviewed by Dr M Hewitt

Review: This is a case study of one of the more common inherited disorders of the white population of Northern European origin. The clinical manifestations and consequences are discussed, along with management and treatment.
Comment: Any old iron.

Musculoskeletal System

25–488 Clinical consult: Marfan syndrome.

Grimes SJ, Acheson LS, Matthews AL, et al. Prim Care. September 2004. Vol.31. No.3. p.739-42.
Reviewed by Dr M Hewitt

Review: The authors present a case study of Marfan syndrome with full details of background, presentation, clinical manifestations and management as well as the hard science of the inheritance and genetics.
Comment: A brief, succinct coverage, with all the appropriate details.

Nutrition

25–489 The impact of obesity on primary care visits.

Bertakis KD, Azari R. Obes Res. 9 September 2005. Vol.13. No.9. p.1615-23.
Reviewed by Dr Anne-Thea McGill

Review: This was a randomised, prospective study of 509 patients assigned for care by 105 primary care resident physicians, who were videoed and analysed using validated Davis Observation Codes. Two-thirds of the clinic patients who had a BMI>30 were not diagnosed as obese. Physicians spent less time educating obese patients about their health ($p<0.0062$) and more time discuss-

ing exercise (p<0.0075). Obesity was not related to discussions regarding nutrition. Physicians spent a greater portion of the visit on technical tasks when the patient was obese (p<0.0528). Mean pre-visit general satisfaction for obese patients was significantly lower than for non-obese patients (p<0.0069); however, there was no difference in post-visit patient satisfaction.
Comment: This study gave a well referenced introduction on how biased primary physician treatment of the obese is and introduced a measure of objectivity into the consult by videoing, the methods of which are edifying in themselves. There was a high rate (40%) of obesity in this study but a number of NZ practices may be similar. That these junior primary care doctors are still having trouble diagnosing and helping the obese with nutrition and are less likely to spend time educating the less healthy, poorer person is an indictment on the health system. It is to be hoped that such studies could be replicated in NZ and medical schools/primary care placements include doctor training to deal with the obesity epidemic.

Obstetrics

25–490 Practical exercise advice during pregnancy: guidelines for active and inactive women.

Kelly AK. Physician and Sportsmedicine. June 2005. Vol.33. No.6. p.24-31.
Reviewed by Dr Rob Campbell
Review: This article reviews the evidence for the benefits and risks of exercise during pregnancy. Also has a handout for patients. In general, exercise at a sensible level is beneficial as long as the contraindications are adhered to.
Comment: A useful guide.

Paediatrics

25–491 Is DEET safe for children?

Flake ZA, Hinojosa JR, Brown M. J Fam Pract. May 2005. Vol.54. No.5. p.468-9.
Reviewed by Dr Bruce Adlam
Review: Generally yes, in children older than two months, with only very rare incidence of major adverse effects. The major reactions reported (among both children and adults) included hypotension, seizures, respiratory distress, and two deaths (0.01%). Typically, a topical concentration between 10% and 30% is used.
Comment: Increasing DEET concentration does not improve protection, but does increase the duration of action so perhaps a lower concentration a little more frequently in the little ones (10% gives two hours protection, 30% gives five).

25–492 The epidemiology of recurrent abdominal pain from two to six years of age: results of a large, population-based study.

Ramchandani PG, Hotopf M, Sandhu B, et al. Pediatrics. July 2005. Vol.116. No.1. p.46-50.
Reviewed by Dr Jocelyn Tracey
Review: This is a large population based cohort study of the prevalence and continuity of recurrent abdominal pain in two to six year olds: present in 6.9% at four years and 11.8% of six year olds. Recurrent abdominal pain is more common in girls, shows strong continuity between two and six years, and is associated with a higher prevalence of headache and limb pain and higher maternal scores for anxiety and depression.
Comment: A useful reminder about the commonness of this problem and the need to alert parents that it is unlikely to quickly disappear.

25–493 The evaluation of sexual abuse in children.

Kellogg N, American Academy of Pediatrics Committee on Child Abuse and Neglect. Pediatrics. August 2005. Vol.116. No.2. p.506-12.
Reviewed by Dr Jocelyn Tracey
Review: This article outlines the medical assessment of sexual abuse in regards to obtaining a history, carrying out a physical examination and obtaining appropriate laboratory investigations and treatment.
Comment: Although written for the US this article still contains a useful overview for those involved in this area.

25–494 Smoking during pregnancy and the risk for hyperkinetic disorder in offspring.

Linnet KM, Wisborg K, Obel C, et al. Pediatrics. August 2005. Vol.116. No.2. p.462-7.
Reviewed by Dr Jocelyn Tracey
Review: This nested case control study utilised data from Danish longitudinal registers that included 170 children with hyperkinetic disorder and 3765 population based control subjects. When adjusted for socioeconomic factors and a history of mental disorders in parents and siblings, the relative risk of ADHD and associated disorders was 1.9 times greater in children whose mothers smoked in pregnancy.
Comment: Another useful piece of information to use when encouraging pregnant women and women contemplating pregnancy to join smoking cessation programmes.

25–495 Childhood obesity and type 2 diabetes mellitus.

Hannon TS, Rao G, Arslanian SA. Pediatrics. August 2005. Vol.116. No.2. p.473-80.
Reviewed by Dr Jocelyn Tracey
Review: Screening is suggested from 10 years for children with BMI >85th percentile and Asian/ Pacific Islander ethnicity and family history using the same tests and values as for adults. Standard therapy includes lifestyle management and Metformin.
Comment: A very useful overview of the pathophysiology, assessment and treatment of Type 2 diabetes in childhood. It's worth getting a full copy of this article.

25–496 Do pacifiers reduce the risk of sudden infant death syndrome?: a meta-analysis.

Hauck FR, Omojokun OO, Siadaty MS. Pediatrics. November 2005. Vol.116. No.5. p.e716-23.
Reviewed by Dr Jocelyn Tracey
Review: This meta-analysis of case control studies demonstrated a beneficial effect of using pacifiers under one year of age; one SIDS death prevented for each 2733 babies with a pacifier for both day and night sleeps.
Comment: With a higher incidence of SIDS in New Zealand the effect is likely to be even stronger.

Physician-Patient Relations

25-497 Is cultural sensitivity sometimes insensitive?

Turner L. Can Fam Physician Med Fam Can. April 2005. Vol.51. p.478-80.
Reviewed by Dr Tim Kenealy
Review: It is interesting to see that 'cultural sensitivity' is an international issue in family practice. The author, an atheist, is concerned that, used inappropriately, *'the concept of culture can serve as a barrier rather than a bridge to understanding'*.
Comment: She does not have the answers, but warns against treating individuals as 'caricatures or cultural types'.

Preventive Medicine

25-498 Motivating patients to move.

Huang N. Aust Fam Physician. June 2005. Vol.34. No.6. p.413-7.
Reviewed by Dr Rachel Monk
Review: Need some more tips on helping your patients to exercise? Have a read of this article. It approaches things differently from the way I was taught and it's sometimes refreshing to have a new way of doing things.

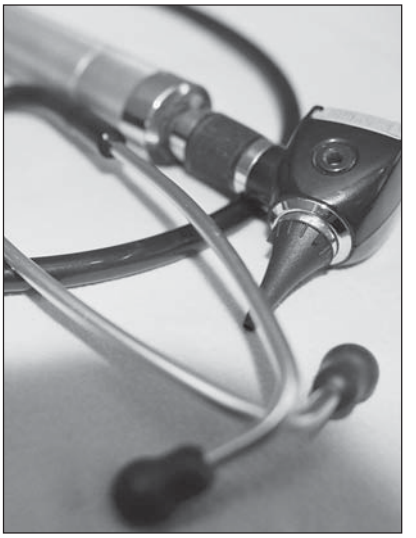
25-499 Exercise and hypertension.

Baster T, Baster-Brooks C. Aust Fam Physician. June 2005. Vol.34. No.6. p.419-24.
Reviewed by Dr Rachel Monk
Review: We all know that exercise is good for people with high blood pressure, but how good and how much? This article looks at the evidence as well as HOW to prescribe exercise for your hypertensive patients.

Primary Health Care

25-500 Assessing fitness to drive Part 1.

Odell M. Aust Fam Physician. May 2005. Vol.34. No.5. p.359-63.
Reviewed by Dr Rachel Monk
Review: Drivers' medicals make up a proportion of GPs' weekly workload so we'd better be sure we're doing it right. This first part of the series focuses on epilepsy, diabetes and cardiovascular disease.
Comment: While the small details may be slightly different in NZ, the underlying general principles are the same.



Psychiatry and Psychology

25-501 Drugs minimally effective for neuropsychiatric symptoms of dementia.

Sink KM, Holden KF, Yaffe K. J Fam Pract. May 2005. Vol.54. No.5. p.407.
Reviewed by Dr Bruce Adlam
Review: This review would suggest pharmacotherapy has a long way to go in improving the lot of patients with dementia. The drugs examined were the new antipsychotics (e.g. risperidone), typical antipsychotics (e.g. haloperidol), SSRIs, mood stabilisers (e.g. valproate), cholinesterase inhibitors (e.g. galantamine). No independent studies indicated a benefit without risk that would compel you to follow one treatment or another. (Original article reviewed see 25- 502).
Comment: The atypical antipsychotics olanzapine and risperidone are the most effective, but these agents may increase the risk of stroke.

25-502 Pharmacological treatment of neuropsychiatric symptoms of dementia: a review of the evidence.

Sink KM, Holden KF, Yaffe K. JAMA. 2 February 2005. Vol.293. No.5. p.596-608.
Reviewed by Dr Bruce Adlam
Review: See 25-501.

25-503 Managing panic disorder in general practice.

Austin D, Blashki G, Barton D et al. Aust Fam Physician. July 2005. Vol.34. No.7. p.563-71.
Reviewed by Dr Rachel Monk
Review: GPs are often the first port of call for people with panic symptoms. Although this article looks briefly at aetiology and diagnosis of panic disorder, it mainly concentrates on management; both psychological and pharmacological.

Respiratory System

25-504 Outpatient treatment as effective as inpatient for many with pneumonia.

Carratala J, Fernandez-Sabe N, Ortega L, et al. J Fam Pract. May 2005. Vol.54. No.5. p.406.
Reviewed by Dr Bruce Adlam
Review: This study has several key findings. Emergency physicians can classify community acquired pneu-

monia patients into risk classes I through III and these patients can be treated as outpatients. Patients who are sent home with a prescription and are visited in two days are more satisfied with their care than inpatients and are just as likely to have a successful outcome. (Original article reviewed see 25-505).
Comment: The risk class index sounds as if it would be easier to use if it were available on computer or PDA.

25–505 Outpatient care compared with hospitalization for community-acquired pneumonia: a randomized trial in low-risk patients.
Carratala J, Fernandez-Sabe N, Ortega L, et al. Ann Intern Med. 1 Febuary 2005. Vol.142. No.3. p.165-72.
Reviewed by Dr Bruce Adlam
Review: See 25-504.

25–506 Spirometry: an essential clinical measurement.
Pierce R. Aust Fam Physician. July 2005. Vol.34. No.7. p.535-9.
Reviewed by Dr Rachel Monk
Review: Need some help understanding and interpreting spirometry? This is the article to read. Step by step approach to spirometry and how it is useful in the management of asthma.

25–507 Shortness of breath: is it chronic obstructive pulmonary disease?
McDonald CF. Aust Fam Physician. July 2005. Vol.34. No.7. p.541-4.
Reviewed by Dr Rachel Monk
Review: Spirometry is essential in the diagnosis of COPD. This article explains why. It also clearly outlines assessment and management of this common chronic disorder.
Comment: Management section primarily focuses on managing stable COPD.

25–508 Pulmonary embolism: assessment and management.
Rees M, Williams TJ. Aust Fam Physician. July 2005. Vol.34. No.7. p.555-61.
Reviewed by Dr Rachel Monk
Review: Need to revisit this uncommon but potentially fatal problem? Have a read of this for a refresher.
Comment: Includes a nice little algorithm to help the doctor through the process.

Sex and Sex Roles

25–509 What happened? Sexual consequences of prostate cancer and its treatment.
Katz A. Can Fam Physician Med Fam Can. July 2005. Vol.51. p.977-982.
Reviewed by Dr Mike Lyons
Review: General review of erectile dysfunction before and after prostatic cancer treatment. Gives percentage figures for the various modalities of treatment. Level 3 evidence suggests using oral therapy on a regular basis even without intercourse to promote erections and lessen fibrosis. For couples not interested in oral or mechanical solutions bibliotherapy is one of the offered suggestions.
Comment: Good reference article to use in dealing with patients undergoing prostate cancer treatment with anticipatory and ongoing counselling.

Sports and Sports Medicine

25–510 Anterior and posterior cruciate ligament injuries.
Brown JR, Trojian TH. Prim Care. December 2004. Vol.31. No.4. p.925-56.
Reviewed by Dr M Hewitt
Review: Using the description of the knee injury and pain presentation, then up to a third of all knee complaints are accounted for by these structures. Again, the history is essential for the description of the mechanism of injury and thus an accurate initial diagnosis is obtained.
Comment: Easily missed on the sideline of the sports field with initial exam. Reassessment is important.

25–511 Medial and lateral collateral injuries: prognosis and treatment.
Quarles JD, Hosey RG. Prim Care. December 2004. Vol.31. No.4. p.957-75.
Reviewed by Dr M Hewitt
Review: A good review of these injuries, which present frequently in primary care settings, and especially those with a sports medicine interest. There is a good description of the anatomy and physical examination technique as well as up-to-date best practice for management.

25–512 Patellofemoral pain syndrome: evaluation and treatment.
LaBella C. Prim Care. December 2004. Vol.31. No.4. p.977-1003.
Reviewed by Dr M Hewitt
Review: A common presentation in general practice, with good background of the aetiology and pathophysiology. Best practice is not always obvious for optimal outcomes. Evidence-based treatments are detailed.
Comment: Worth reading several times.

25–513 Soft-tissue injuries of the lower extremity.
Glazer JL, Hosey RG. Prim Care. December 2004. Vol.31. No.4. p.1005-24.
Reviewed by Dr M Hewitt
Review: The common ones being those seen in the active population with sport injuries. These are hamstring strains, calf muscle strains, medial tibial stress syndromes and plantar fasciitis.
Comment: All aspects of treatments are considered and reviewed with regard to best practice.

25–514 The ankle examination.
Harmon KG. Prim Care. December 2004. Vol.31. No.4. p.1025-37.
Reviewed by Dr M Hewitt
Review: Comprehensive coverage of the anatomy and functional biomechanics of the ankle. Descriptions of common types of injury mechanisms are given in order to assist accurate clinical diagnosis and treatment.
Comment: A good update.

25–515 Achilles tendonopathy and tendon rupture: conservative versus surgical management.

Morelli V, James E. Prim Care. December 2004. Vol.31. No.4. p.1039-54.

Reviewed by Dr M Hewitt

Review: The range of trauma to the tendon includes tendonitis, bursitis as well as partial or complete rupture. A range of effective treatments are described, along with analysis as to the most appropriate treatment in the case of complete rupture.

Comment: As in all cases, treatment must be tailored to the unique circumstances of the individual, and be acceptable and meet expectations.

25–516 Eccentric strengthening: clinical applications to Achilles tendonopathy.

Jeffery R, Cronin J, Bressel E. New Zealand Journal of Sports Medicine. Winter 2005. Vol.33. No.1. p.22-30.

Reviewed by Dr Rob Campbell

Review: This paper reviews the research to date on eccentric training in Achilles tendonopathy and then the clinical applications. 'Best practice' is yet to be evidence based but good guidelines are now available.

Comment: An excellent review of the present evidence. Most patients will now be prescribed eccentric training for tendonopathy so it is worth reading this paper.

25–517 Complete rupture of large tendons: risk factors, signs, and definitive treatment.

Flik KR, Bush-Joseph CA, Bach BR. Physician and Sportsmedicine. August 2005. Vol.33. No.8. p.33-8.

Reviewed by Dr Rob Campbell

Review: A summary of ruptures of the large tendons, i.e. pectoralis major, distal biceps, quadriceps, patella, Achilles and rotator cuff. The risk factors are described and the signs are detailed, especially the commonly misdiagnosed ruptures.

Comment: A very useful paper, especially if you don't see many of these, as most are best treated surgically as early as possible except some Achilles ruptures.

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