Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Acupunct Med*
Age Ageing*
Am Fam Physician*
Aust Fam Physician*
Best Pract*
BMJ*
Br J Sports Med*
Can Fam Physician*
Drug Ther Bull*
Intern Med J*
J Altern Complement Med*
Joint Bone Spine*
Lancet*
N Engl J Med*
Obesity*
Pain*
Palliat Med*
*Journals indexed in Medline

Acupuncture

28-391 Acupuncture modulates resting state connectivity in default and sensorimotor brain networks

Dhond RP, Yeh C, Park K, et al. Pain. 15 June 2008. Vol.136. No.3. p.407-18.
Reviewed by Dr Alex Chan

Review: Resting-state networks are patterns of inter-related active brain regions recorded by fMRI when a subject is not performing any task. Several such networks have been identified, including a Default Mode Network (DMN), cognitive, sensorimotor (SMN), visual and other networks. Real acupuncture in healthy participants, as opposed to sham acupuncture, was found to increase connectivity of the DMN with pain, emotion, and memory related regions of the resting brain. It also increased the connectivity of the SMN with pain-related brain regions.

Comment: A recent study found differences in DMN function in patients with chronic pain compared to controls. The findings of this article were highlighted and discussed in an editorial of the same issue of the *Pain* journal (see 28-392 for editorial). It opens another door in investigating the mechanism of acupuncture (and possibly of other forms of Energetic Medicine) on the human body.

28-392 Acupuncture and the CNS: what can the brain at rest suggest?

Seminowicz DA. Pain. 15 June 2008. Vol.136. No.3. p.230-31.
Reviewed by Dr Alex Chan

Review: The editorial on article 28-391.

28-393 Laser acupuncture in children with headache: a double-blind, randomized, bicenter, placebo-controlled trial

Gottschling S, Meyer S, Gribova I, et al. Pain. 15 July 2008. Vol.137. No.2. p.405-12.
Reviewed by Dr Alex Chan

Review: Low level laser acupuncture treatment was found to be superior to placebo laser treatment for migraine or tension headache in children in this prospective, randomised, double-blind, placebo-controlled trial. Comparing with the placebo group, there was significant reduction in frequency of headaches per month, and in pain intensity when headaches occurred in the treatment group. Interestingly, there was no significant change in the duration of headache when an attack occurred.

Comment: 30 mW, 830 nm, continuous wave laser of a power density of 3.8 W/cm2 was applied for 30 seconds to selected acupuncture points weekly. Invisible laser and the lack of acute skin sensation from laser

application allowed double-blindedness and placebo-control in this well conducted trial.

28-394 The chinese back shu and front mu points and their segmental innervation

Mayor DF. Deutsche Zeitschrift fur Akupunktur. 2 July 2008. Vol.51. No.2. p.26-36.
Reviewed by Dr Alex Chan

Review: Based on published studies and authoritative resources, the author, in this review article, matched the autonomic innervations of the internal organs with the dermatomal and myotomal innervations of the back Shu and front Mu points. As expected, because of overlapped innervations of individual acupoints, it appeared that, on the basis of segmental innervation, there was no justification for selecting the traditional back Shu and front Mu points for an organ rather than other adjacent acupoints. Other interesting findings include a slightly greater correspondence with the associated organ for the front Mu points than for the back Shu points, and the dermatomes of the back Shu points have greater correspondence than the myotomes of the same points.
Comment: This article contains the most comprehensive up-to-date information of the segmental innervations of the Shu and Mu points. Sensitivity of the points and adjacent areas should still be the best guidance for acupoint selection in clinical practice.

28-395 Acupuncture-associated Listeria monocytogenes arthritis in a patient with rheumatoid arthritis

Tien C, Huang G, Chang C, et al. Joint Bone Spine. July 2008. Vol.75. No.4. p.502-3.
Reviewed by Dr Alex Chan

Review: This is a case report of septic arthritis following acupuncture where the needles were re-sterilised and re-used. An afebrile patient presented with swelling and pain in the affected knee but without redness or local heat. Diagnosis of septic arthritis was made following ultrasound, MRI, examination and culture of an aspiration from the knee.
Comment: Always use disposable needles. A joint can still be septic in the absence of constitutional upset, local redness or heat.

28-396 Defining an adequate dose of acupuncture using a neurophysiological approach – a narrative review of the literature

White A, Cummings M, Barlas P, et al. Acupunct Med. June 2008. Vol.26. No.2. p.111-20.
Reviewed by Dr Alex Chan

Review: Many questions have been raised when results of acupuncture clinical trials did not correlate with practical clinical experience of the acupuncturists. One of the questions was whether the treatment groups in the trials had been given an adequate 'dose' of acupuncture. A group of academics reviewed the literature and posted their definition of an adequate dose of acupuncture for debate. According to the group, the amount of stimulation, the patient's resulting perception and other responses have to be taken into consideration in defining an adequate dose.
Comment: A highly readable article. The definition could only be a framework for future discussion and exploration. Further physiological evaluations are required for the weightings of the different components in the definition. For example, laser acupuncture, ear acupuncture and some forms of Japanese acupuncture may not necessarily produce the classical deqi sensation but could still be effective clinically. It is possible that some form of measurable physiological response such as changes in parasympathetic or sympathetic changes are more important, reproducible and standardised in this regard.

28-397 Can classical acupuncture points and trigger points be compared in the treatment of pain disorders? Birch's analysis revisited

Dorsher PT. J Altern Complement Med. May 2008. Vol.14. No.4. p.353-9.
Reviewed by Dr Alex Chan

Review: The author reviewed the literature and, as opposed to Birch, supported Melzack et al.'s 1977 report on very high anatomic and clinical pain correspondences of myofascial trigger points and classical acupuncture points in the treatment of pain disorders. It was his interpretation that the myofascial pain tradition represented a re-discovery of illness treatment principles of traditional Chinese medicine (TCM) that was described in the Nei Jing. The two traditions were presented in different cultures and era using different terminologies and methodologies. According to the author, other cultures such as Egypt and the Mayan also had similar concepts to those of TCM.

Comment: Interesting article from the Department of Physical Medicine and Rehabilitation of the Mayo Clinic. Highly recommended reading. In the future the author will also report on correspondences of referred pain patterns and acupuncture meridian distributions. So, watch the space.

28-398 Manual acupuncture improved quality of life in cancer patients with radiation-induced Xerostomia

Cho JH, Chung WK, Kang W, et al. J Altern Complement Med. June 2008. Vol.14. No.5. p.523-6.

Reviewed by Dr Alex Chan

Review: Applying acupuncture at ST-6, LI-4, ST-36 and SP-6 twice a week for six weeks was found to significantly improve unstimulated salivary secretion six weeks after the course of treatment in this small scale study of 12 post-radiation xerostomia patients when compared to sham acupuncture. Sham acupuncture was provided by needling non-acupuncture points 2cm away from the real points and superficially.

Comment: Results of small scale studies have many limitations and are not for generalisation but provides information for further trials. However, sometimes people might find comfort in having affirmation to what they having been experiencing.

Alcohol and Substance Abuse

28-399 Quality of life, depression and anxiety in alcohol dependence

Saatcioglu O, Yapici A, Cakmak D. Drug Alcohol Rev. January 2008. Vol.27. No.1. p.83-90.

Reviewed by Dr Helen Moriarty

Review: 150 alcohol-dependent hospital patients were studied before and at three and six weeks after their withdrawal symptoms ended, using a psychiatric interview and a quality of life survey. This paper compares participants presenting with alcohol dependence plus depression or anxiety with those just alcohol dependent. Concurrent anxiety and depression both increased the severity of the alcohol withdrawal symptoms, and also had a negative effect on quality of life.

Comment: This somewhat expected result does raise additional questions about which comes first, the lowering of quality of life or the anxiety and depression. It is always wise to screen alcohol dependent persons for co-existing morbidities since these warrant management in addition to managing the alcohol withdrawal.

28-400 Barriers to, and incentives for, the transfer of opioid-dependent people on methadone maintenance treatment from secondary care to primary health care

Sheridan J, Goodyear-Smith F, Butler R, et al. Drug Alcohol Rev. March 2008. Vol.27. No.2. p.83-90.

Reviewed by Dr Helen Moriarty

Review: A survey of 77 methadone authorised GPs, 74 GP scripted methadone patients, 20 methadone clinic staff and 23 clinic patients, sought to better understand reasons why methadone clinic clients do not transfer readily to GP care. The questionnaire included response options and free field comment. Eighty-three per cent of the responding methadone clinic patients and 65% of the clinic staff believed that the GP would not be as knowledgeable and similar proportions thought that the care would be as good. Cost to see the GP for their methadone was a major worry for transferring patients as there are no fees at the clinic. Thirty-two per cent of the responding GPs did not want to take on any more methadone patients.

Comment: This paper identified really important barriers of attitude

The first, and last, JRS editorial!

Not really an editorial but certainly an acknowledgement of the contribution all the reviewers have made to the JRS over the many years of its existence. They were all voluntary (I can assure you that no reviewers were physically harmed in the recruitment process!) and collectively would have given thousands of hours in reducing the reading burden of their colleagues. I had intended to name everyone, and had even started a list from the early issues, but it soon became obvious that the list would occupy too much space. I would like to think that, at some point, all the reviewers, past and present, would take a bow, pat themselves on the back, or have a celebratory drink in honour of a job well done! Well done reviewers!

The contribution of Mrs Margaret Gibson Smith, Philson Librarian, who came up with the idea of the JRS, and Dr Phil Barham, Foundation Director of the Goodfellow Unit, who supported the creation of the JRS, will no doubt be recorded as a milestone in the history of the GFU. Also deserving of acknowledgment and thanks are previous editors of the JRS, staff of the Philson Library who expertly indexed and entered all the reviews, and all the part-time workers who did the photocopying. Over the last good numbers of years, which means I can't remember how long, I have worked with Lorraine Nielsen of the Philson Library; I would like to thank her for the extended hours she worked to meet deadlines, for the care she took in getting things right, and for listening to all my grumbles.

No doubt, after I have sent this off, I will wake in the middle of a night with that dreadful feeling, 'I forgot to mention...!' Sorry!

All the best
Dennis Kerins

issues arising from within methadone clinics towards GPs and their care, and also touched upon the capping of treatment numbers in NZ and lack of transfer of clinic funding into the community with the patient. However, the discussion and conclusion both failed to expand upon these.

Asthma

28–401 Switching to CFC-free beclometasone for Asthma

Drug Ther Bull. June 2008. Vol.47. No.4. p.46-8.

Reviewed by Fiona Corbin

Review: This article examines the differences between chlorofluorocarbon (CFC)-containing and CFC-free presentations of inhaled beclometasone available in the UK. The evidence presented demonstrates that the two CFC-free products available are not bioequivalent and suggests that the Qvar® brand might be as much as two and a half times more potent than the currently available CFC-containing brands. The paper makes useful suggestions for managing the change from one to the other in practice.

Comment: In New Zealand the currently funded inhaled beclometasone is Beclazone® which contains chlorofluorocarbons. The Qvar® brand is registered by MedSafe in New Zealand but is currently unfunded. As a party to the Montreal Protocol, the phasing out of CFC-containing Metered Dose Inhalers will continue in New Zealand. It is conceivable that at some point New Zealand prescribers will be required to manage such switches. This article is a useful supporting resource.

Cardiovascular System

28–402 Reducing the risk of adverse thrombotic events – the role of aspirin and clopidogrel

Jackowski L, Stocks N, Rowett D. Aust Fam Physician. September 2008. Vol.37. No.9. p.721-6.

Reviewed by Dr Mary Tucker

Review: Aspirin and clopidogrel inhibit platelet aggregation by different methods and may have an additive effect in the prevention of coronary artery thrombosis. An evidence-based summary of the indications for the use of these agents, alone or in combination, in the prevention of thrombosis is presented. For both drugs the risk of gastro-intestinal bleeding can be reduced by the use of a proton pump inhibitor. In atrial fibrillation, warfarin is used for prevention of stroke in moderate to high risk patients while aspirin is used in those at low risk of stroke.

Comment: Aspirin should be used in primary prevention of cardiovascular thrombosis if the five year cardiovascular risk is >15% and for secondary prevention in stable cardiovascular disease. Aspirin and clopidogrel should be used in combination for 12 months following bare metal stent insertion in acute coronary syndrome and indefinitely for drug eluting stents used in high risk patients. When bare metal stents are used in the elective situation, combination therapy should be used for at least one month and up to 12 months in cases with low risk of bleeding and extensive vascular disease. In all cases, combination therapy should be followed by long term ongoing aspirin therapy. Clopidogrel should only be considered for use as monotherapy for secondary prevention in cases of aspirin intolerance.

28–403 Does treating hypertension in the very elderly improve outcomes?

J Fam Pract. August 2008. Vol.57. No.8. p.506-7.

Reviewed by Dr Bruce Adlam

Review: Yes. Treatment of hypertension in patients older than 80 reduces the risk of fatal stroke and death from any cause. Previous studies using high-dose diuretics and beta- blockers had not found a similar benefit, perhaps because of the adverse effects of high-dose diuretics and the lack of benefit of beta-blockers. Level of evidence = 1b. In this study patients were randomly assigned to receive sustained-release indapamide 1.5 mg daily or placebo. Patients with recent stroke, secondary or accelerated hypertension, heart failure, or renal impairment were excluded. If the target blood pressure of 150/80 mm Hg was not achieved, perindopril (2 or 4 mg) or matching placebo could be added.

Comment: Treatment leads to fewer cardiovascular events. Patients in the active treatment group had lower rates of fatal stroke (6.5% vs 10.7%; P = .046; number needed to treat [NNT] = 24), all-cause mortality (47.2% vs 59.6%; P = .02; NNT = 8), heart failure (5.3% vs 14.8%; P<.001; NNT = 10.5), and any cardiovascular event (33.7% vs 50.6%; P<.001; NNT = 5.9). There were fewer serious adverse events in the active treatment group, as well. (Original article reviewed: N Engl J Med. 2008; 358:1887-1898)

28–404 How does the 'NICE' approach to lipid lowering differ from that of the US?

J Fam Pract. September 2008. Vol.57. No.9. p.574-5.

Reviewed by Dr Bruce Adlam

Review: The British National Institute of Clinical Effectiveness (NICE) guidelines indicate that it's the baseline cardiovascular risk, and not baseline lipid levels, that is of primary importance when making decisions about lipid-lowering treatment. For patients with elevated lipid levels but without heart disease, the guidelines suggest initiating treatment only if patients have a 10-year risk of 20%. For this primary prevention, the guidelines suggest a hands-off approach of treating with simvastatin 40 mg daily and not checking follow-up cholesterol. For patients with heart disease, the guidelines suggest starting with the same dose, but checking response and increasing the dose when necessary.

Comment: They apply these guidelines to men and women, although cholesterol treatment in women has

not been shown to decrease mortality. (Original article reviewed: BMJ. 2008;336:1246-1248)

28-405 Will screening individuals at high risk of cardiovascular events deliver large benefits? Yes

Jackson R, Wells S, Rodgers A. BMJ. 28 August 2008. Vol.337. p.a 1371 (1 page)
Reviewed by Dr Len Brake

Review: Assuming the continuation of population-based GP funding after November 2008, these views are intensely relevant to New Zealand primary care. Epidemiology is a developing science and is a mile away from the realities of clinical practice. The occasional foray of the epidemiologist into the battlefield of daily general practice sends them scuttling back to the ivory tower in short order. Yet we as GPs rely on their counting the score. I have been a GP since the early 1970s and if I was asked to say whether you live longer if you are fat or skinny I couldn't say. I am as observant as anyone but even the fact that smokers are doomed is a hard call to make in the absence of epidemiological evidence. So we need them almost as much as they need us. Patients don't take their pills, they make their own minds up about which side effects to withstand – if any, a dodgy diastolic pressure or a limp penis – come on doc! One television programme and BOOM 25% of your high cholesterol patients stop their statins and reckon on 'joining the gym' as a more natural way of sorting the problem. Then there's the not uncommon poser like the un-enrolled overweight 55-year-old with hypertension, a heavy smoker who pops in for 'a few more gout pills please' five minutes before closing on a Friday night.

Comment: These two reports are a MUST READ (see 28-406 for the negative). In any event the two opposing points of view are not it seems to me mutually exclusive. There is room for agreement on a way forward – so optimism rules. When an epidemiologist makes a call for action it is more important than ever for the GP group to take a considered look at all evidence available, flavouring this with the realities often unknown to the academics. Then the GPs make the final decision on how to proceed. Better that than becoming the infantry dung beetle being sent over the top by a distant officer specialist! (Editor – Len has reviewed for the JRS for more years than either of us can remember so, given his senior status, I have included his final comments: *'On behalf of all reviewers I would like to thank Dennis Kerins our leader. I have been one of his minions for ?? years and I have treated the man with laziness, incompetence and remarkable slothfulness but he has always been polite and friendly, indeed charming to me. I have it from behind the scenes that my reviews have required the most editing of all his writers so apologies for all the trouble mate but we had a few laughs along the way. Cheers, Len Brake.*')

28-406 Will screening individuals at high risk of cardiovascular events deliver large benefits? No

Capewell S. BMJ. 28 August 2008. Vol.337. p.a1395 (1 page)

Review: See 28-405.

Chronic Disease Management

28-407 Chronic disease management

Presser J. Aust Fam Physician. September 2008. Vol.37. No.9. p.693.
Reviewed by Dr Mary Tucker

Review: This editorial summarises the focus of this issue on chronic disease management (see 28-408 to 28-412), looking especially at asthma, diabetes, cancer and depression. In general practice, disease prevention, from a public health perspective, has become a key issue in the management of these chronic conditions, while guidelines to optimise care in established cases, and available tools and resources for general practitioners encourage more consistent implementation of a high standard of care.

Comment: The authors covering these topics offer their answers, in each case, to the question: *'How can we do this better?'*

28-408 The management of chronic problems

O'Halloran J, Harrison C, Britt H. Aust Fam Physician. September 2008. Vol.37. No.9. p.697.
Reviewed by Dr Mary Tucker

Review: The BEACH program (Bettering the Evaluation and Care of Health) shows that at least one chronic problem was managed at 39.7% of general practice encounters. Chronic problems were managed at a rate of 7.8 per 100 encounters in patients aged one to four years, increasing to a rate of 86.2 per 100 encounters in those aged 75 to 84 years. Hypertension was the commonest problem managed accounting for 18.3% of all chronic problems. Other frequently managed chronic problems included non-gestational diabetes and depressive disorders (each 3.7 per 100 encounters), lipid disorders (3.5 per 100) and osteoarthritis (2.6 per 100).

Comment: Setting the scene for an issue focusing on the management of chronic diseases.

28-409 The role of general practice in cancer care

Mitchell GK. Aust Fam Physician. September 2008. Vol.37. No.9. p.698-702.
Reviewed by Dr Mary Tucker

Review: Increased life expectancy is associated with a rising incidence of cancer and improved treatment has resulted in improved survivorship. General practitioners have a critical role to play in the early detection of cancer, especially in those presenting with an atypical history when a high index of suspicion must be maintained in order to maximise the chance of cure. The need to take time to discuss, with a patient, a presumptive cancer diagnosis, necessary investigations and need for referral and the importance of a confidant for support of the patient at this time is emphasized. The general practitioner can initiate preliminary investigations and ensure that referral is made

to an appropriate specialist. For cancer survivors there may be long-term complications from chemotherapy, radiotherapy and surgery to be managed. For those with recurrent disease requiring palliative care the GP has an important role to play in referral to palliative care services and ongoing shared care. The importance of the general practitioner in caring for caregivers is highlighted.

Comment: The role of GPs in cancer care will expand in years to come. In the associated mp3*, Professor Mitchell discusses the role of the GP in the early diagnosis of cancer, in improving the care of cancer survivors and in support of their carers. Where multidisciplinary teams are in place, liaison with these teams, especially in the case of rare cancers, enables provision of optimal care. The GP can provide critical background information that may assist in planning and ensure that adequate social support will be provided and has an important role to play in surveillance during therapy, the management of side effects and in the proactive management of anxiety. The development of protocols should facilitate appropriate management in a cost-effective fashion and the development of web-based technology will facilitate information sharing and cooperation between primary care and specialist care. Links to resources on the New South Wales Cancer Institute site are provided for health professionals and for patients and their caregivers.

*http://www.racgp.org.au/AM/Template.cfm?Section=AFP_Podcasts&Template=/CM/ContentDisplay.cfm&ContentID=26974

28-410 Management of recurrent depression

Howell C, Marshall C, Opolski M. Aust Fam Physician. September 2008. Vol.37. No.9. p.704-8.

Reviewed by Dr Mary Tucker

Review: As the majority of cases of depression run a chronic course (77.5% of patients will suffer a relapse or recurrence of the illness over a five-year period) it is important for the general practice and mental health services multidisciplinary teams to develop a chronic disease management plan, in collaboration with the patient, to facilitate self management. Patients who are actively involved in the health care process have better outcomes. Current guidelines recommend antidepressant therapy for at least one year – up to three years if there is a risk of recurrence. Campaigns to remove the stigma of depression encourage patients to seek treatment, and registers and reminder systems in general practice facilitate active follow-up of patients in collaboration with mental health professionals. Recommendations from depression treatment guidelines are summarised. The role of antidepressant therapy in early improvement, of psychological therapy in improving long-term outcomes, the importance of the recognition of risk factors for depression relapse, and management plans for dealing with early relapse symptoms are highlighted.

Comment: In the associated mp3*, Dr Cate Howell discusses the chronic nature of depressive illness and explores the concepts of depression relapse and recurrence, risk factors for relapse, protective factors for prevention of relapse and the implementation of a depression management plan that includes relapse prevention.

*http://www.racgp.org.au/AM/Template.cfm?Section=AFP_Podcasts&Template=/CM/ContentDisplay.cfm&ContentID=26974

28-411 Asthma management in general practice – a chronic disease health priority

Rudolphy S. Aust Fam Physician. September 2008. Vol.37. No.9. p.710-4.

Reviewed by Dr Mary Tucker

Review: Improvements in the delivery of asthma care in Australia are required because of high asthma prevalence and mortality. A national survey identified socio-economic factors, lack of a written asthma plan, failure to use inhaled corticosteroids regularly and active and passive smoking as areas in need of improvement. There were higher levels of self-reported ill health in several areas among asthmatics. This article provides an evidence-based overview of asthma management based on the National Asthma Council of Australia's asthma management handbook. The diagnosis of asthma and assessment of its severity in children and adults, its differentiation from COPD and the identification of other treatable co-morbidities (e.g. allergic rhinitis) are discussed. Assessment and management tools are provided and the importance of education and regular review are emphasized.

Comment: Excellent resources can be found on the National Asthma Council of Australia's website http://www.nationalasthma.org.au/html/home/index.asp. In the associated mp3*, Dr Rudolphy discusses issues related to the article, including the importance of spirometry and the goal of provision of elite asthma management in Australia.

*http://www.racgp.org.au/AM/Template.cfm?Section=AFP_Podcasts&Template=/CM/ContentDisplay.cfm&ContentID=26974

28-412 Challenges in diabetes management

Harris M. Aust Fam Physician. September 2008. Vol.37. No.9. p.716-20.

Reviewed by Dr Mary Tucker

Review: This article outlines the early detection and management of type 2 diabetes (a major cardiovascular and microvascular disease risk factor) in the general practice setting. Increasing prevalence of diabetes is related to population ageing and the increasing prevalence of risk factors. The AUSDRISK questionnaire is the first measure in a stepped approach to screening patients for type 2 diabetes. A fasting glucose of 7.0 mmol/l (non fasting >11.1mmol/l) suggests diabetes and there is evidence that HbA1c maybe useful as a screening test for both diabetes and metabolic syndrome. The importance of close monitoring of metabolic control and the early detection of diabetic com-

plications using annual screening is discussed. High risk patients, with multiple risk factors, must be identified: especially those with obesity, smoking, dyslipidaemia, poor glycaemic and blood pressure control and /or early complications. Complications can be prevented or delayed by targeted use of medication to optimise glycaemic, lipid and blood pressure control, prescription of aspirin and lifestyle changes including increased physical activity, dietary changes to achieve weight reduction and smoking cessation.

Comment: Although the principles of diabetic control are well known, up to 50% of patients are poorly controlled. More extensive patient education programmes to support self management skills, provision of multidisciplinary team care and decision support and information systems including patient registers, recall systems, templates for care plans and guidelines for health professionals have been shown to improve outcomes. Electronic resources are provided.

Diabetes

28-413 Three new drugs for type 2 diabetes

Drug Ther Bull. June 2008. Vol.46. No.7. p.49-52.

Reviewed by Fiona Corbin

Review: This bulletin considers three new drugs in two new drug classes that act on the hormonal regulation of insulin secretion. Incretins are intestinal hormones that stimulant post-prandial secretion of insulin. They include glucose-dependent insulinotropic polypeptide (GIP) and glucagon-like peptide 1 (GLP-1). These hormones interact with specific receptors in pancreatic islet beta cells which stimulate glucose-dependent insulin secretion. These hormones are rapidly degraded in the circulation by dipeptidyl peptidase-4 enzyme (DPP-4). Drugs have been developed which enhance incretin activity either by mimicking GIP or GLP-1, or by inhibiting DPP-4. Three examples are the topic of this bulletin, which reviews the available evidence for these agents and places them in context with other established drugs used in management of type 2 diabetes.

Comment: The available evidence and clinical experience related to use of exanatide (GLP-1 mimetic) and sitagliptin and vildagliptin (both DPP-4 inhibitors) is as yet relatively limited and suggests that the effect of these agents on reducing HbA1c is little better than what can be achieved with other oral antihypoglycaemic drugs. Longer term safety studies and studies with patient orientated outcomes are also lacking. At this stage it appears highly unlikely that these particular agents will revolutionise the management of type 2 diabetes.

28-414 Effects of intensive glucose lowering in type 2 diabetes

The Action to Control Cardiovascular Risk in Diabetes Study Group. N Engl J Med. 12 June 2008. Vol.358. No.24. p.2545-59.

Reviewed by Dr Raina Elley

Review: Intensive glucose-lowering therapy (median HbA1c 6.4%) caused a significant increase in mortality compared with standard therapy (median HbA1c 7.5%) according to the ACCORD randomised controlled trial. This trial included 10 251 people with type 2 diabetes (mean age 62 years) who had a median HbA1c of 8.1% at baseline. Thirty-five per cent had previous CVD. The primary outcome was any cardiovascular event. The trial was stopped after 3.5 years because, although there was a trend towards decreased CVD events in the intensive compared with the control group, all cause and CVD mortality was greater.

Comment: Does this mean that reducing HbA1c to below the current target of 7% may be harmful? Observational studies, including our own Diabetes Cohort Study have shown a continuous decrease in CVD risk with decreasing HbA1c after controlling for traditional CV risk factors. The ACCORD trial compares two treatment regimes and it may be in the regimes, rather than the HbA1c level, that the harm was caused. For example, the intensive therapy arm of the ACCORD trial had high rates of insulin and thiazolidinediones (92% in intensive arm compared with 58% in standard therapy arm) (mostly rosiglitazone that has been shown in a meta-analysis to increase risk of MI (Nissen 2007)), rapid drop in glycaemia (absolute drop of 1.4% in first four months) and rapid weight increase (mean increase 3.5kg from baseline with 28% having more than 10kg increase). The increase in all-cause mortality may had been contributed to by the multiple and rapid drug changes, drug types or interactions, rapid drop in glycaemia (with high hypoglycaemic rates), and/or other drug adverse effects such as weight increase or fluid retention, which were more common in the intensive therapy group than the control group. The ADVANCE trial (see 28-415 – 28-417), reported in the same edition of NEJM which also compared a lower HbA1c target (median 6.5% achieved in intensive arm) with standard therapy, did not find an increase in all-cause mortality, but also did not have the high rates of thiazolidinediones in combination with insulin that were used in ACCORD. A recent perspective in NEJM suggests that hypoglycaemic medications should be assessed for their effect on CVD outcomes, in addition to diabetes complications. In addition to rosiglitazone, studies of sulphonylureas have suggested a detrimental effect on CV risk (see 28-418). Neither the ACCORD nor the ADVANCE trial used lifestyle interventions, which probably would not have caused the adverse effects suggested. Perhaps we need to invest far more in lifestyle (dietary and exercise) interventions both in the prevention and management of type 2 diabetes.

28-415 Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes

The ADVANCE Collaborative Group. N Engl J Med. 12 June 2008. Vol.358. No.24. p.2560-72.

Reviewed by Dr Raina Elley

Review: In a RCT of 11 140 people with type 2 diabetes, intensive glucose control (median HbA1c 6.5%) using gliclazide plus other drugs as required, compared with standard therapy (median HbA1c 7.3%) decreased the incidence of combined macrovascular and microvascular events after five years. However, there was only a non-significant trend (HR 0.94 (95% CI, 0.84 to 1.06)) for major macrovascular events and the effect on microvascular events was primarily due to the substantial reduction of nephropathy (not retinopathy). There was no significant effect overall on mortality and adverse events, particularly severe hypoglycaemia, were higher in the intensive arm.
Comment: This trial, like the ACCORD trial, found that intensive glycaemic control (below the traditional HbA1c 7% target) did not significantly reduce CVD events. However, the fact that this trial did not find increased mortality with intensive HbA1c control suggests that the increase in mortality seen in the ACCORD trial may have been more to do with the medication regimen than the HbA1c level.

28–416 Intensive glycemic control in the ACCORD and ADVANCE trials

Dluhy RG, McMahon GT. 12 June 2008. Vol.358. No.24. p.2630-33.
Reviewed by Dr Raina Elley

Review: This is one of two interesting editorials on the ACCORD and ADVANCE trials discussing the possible explanations for the findings and the implications for clinical practice. The intensive therapy in the ACCORD trial increased CVD mortality. These authors suggest that many of the deaths were only presumed to be cardiac and could have been due to adverse events of the intensive regimens, such as hypoglycaemia. The lack of reduction of CVD events in the two trials may also be related to the variable management of other CVD risk factors (such as relatively low rates of aspirin and statin use in the ADVANCE trial). The authors also point out that while tight control of glycaemia may reduce microvascular effects, it may not contribute as significantly to reversal of atherosclerosis. Once glycaemic levels have reached high levels they are often accompanied by hyperlipidaemia, raised blood pressure and hypercoagulability. Therefore, to reduce CV risk, the controlled glycaemia must be accompanied by BP lowering, lipid-lowering and aspirin therapy. These authors conclude that the two trials did not show that intensive glycaemic control is protective against CV events and deaths, and that we should retain our target of HbA1c 7% in the mean time.

28–417 Glycemic targets and cardiovascular disease

Cefalu WT. N Engl J Med. 12 June 2008. Vol.358. No.24. p.2633-5.
Reviewed by Dr Raina Elley

Review: This is the other editorial commenting on the ACCORD and ADVANCE trials. This author says that although mortality increased in the intensive arm of the ACCORD trial, the incidence of CVD events overall was decreasing and the incidence of MI was actually significantly lower by the time the trial was stopped at 3.5 years. There was also no increase in mortality with intensive treatment in the ADVANCE trial. To explain the differences in clinical outcomes between the two trials, Cefalu points out that in the ACCORD trial, the rate of reduction in HbA1c in the intensive arm was very rapid and the rate of decline may have contributed to the different outcomes of the two trials. Secondly, there were high rates of thiazolidinediones and insulin in the ACCORD trial compared with the ADVANCE trial. Although, when drug use was controlled for, this did not explain the increase in mortality. Thirdly, Cefalu suggests there were differences in weight gain. The fact that the intensive therapy produced significant weight gain in the ACCORD trial demonstrates how HbA1c reduction from this intensive drug therapy is quite different from HbA1c reduction from lifestyle intervention, which is usually accompanied by weight loss. This author concludes that in this high CV risk group we may be best to continue our HbA1c target of 7% until further research clarifies the issues more.

28–418 Assessing the cardiovascular safety of diabetes therapies

Goldfine AB. N Engl J Med. 11 September 2008. Vol.359. No.11. p.1092-5.
Reviewed by Dr Raina Elley

Review: This is an interesting commentary. To assess the clinical effectiveness of a type 2 diabetes therapy, the FDA use the surrogate outcome of HbA1c. Real clinical effectiveness means reducing the acute symptoms of hyperglycaemia and slowing the progression to diabetes-related complications. Although the short-term effects and effects on microvascular complications are well described for most currently-used agents, their effect on macrovascular (CVD) complications is still not well understood. A recent meta-analysis of rosiglitazone (Avandia) showed an increased odds ratio of 1.43 for myocardial ischaemia. Early trials of sulphonylureas suggested an increase in CV risk, and insurance surveillance data support this finding. The ACCORD trial showed an increase in mortality with intensive glycaemic regimens (although further analysis did not show rosiglitasone was significantly linked to CV events) but the ADVANCE trial did not show increased mortality. The FDA is debating whether drug companies must demonstrate effects on CV events before approval. However, these trials would have to be large and long so may remain impractical prior to drug approval.
Comment: In the meantime, as clinicians we have to decide what is best for patients without full knowledge. However, we know that ensuring BP-lowering, aspirin, and statin (or other lipid lowering) treatment will lower CV risk, and this should remain an additional focus to glycaemic control. Furthermore, lifestyle change at a population, policy, cultural and individual level could hugely reduce

the need for drugs both in preventing and managing diabetes, but it remains a poorly funded route for intervention.

28–419 Atypical antipsychotic–induced diabetes mellitus: an update on epidemiology and postulated mechanisms

Buchholz S, Morrow AF, Coleman PL. Intern Med J. July 2008. Vol.38. No.7. p.602-6.
Reviewed by Dr Helen Moriarty

Review: A review based on a rare case of anti-psychotic induced diabetic ketoacidosis reminds us that such rare events can cause collapse at home. This is not just due to weight gain (the patient in fact had lost 20kg through dieting and exercise in the preceding 12 months). Metabolic syndrome is more common on these agents. Family history and altered insulin sensitivity mediated by 5HT are also thought to play a role.
Comment: GPs, patients and families need to be aware of the diabetogenic potential of these agents, and to monitor fasting blood as well as HbA1c.

28–420 Treating the diabetic patient with leg and foot pain

J Fam Pract. May 2008. Vol.57. No.5. p.S4-7.
Reviewed by Dr Bruce Adlam

Review: Neuropathies affect more than 50% of patients with diabetes. Good glycaemic control is a key factor in preventing DPN, and early detection can help to prevent limb deterioration, amputation, and other negative sequelae associated with DPN. Optimal management of patients with DPN requires a combination of nonpharmacologic and pharmacologic treatment strategies.
Comment: Quite a good case-based article, with useful approach and treatment tables. Useful peer group resource.

Gastroenterology

28–421 A fire inside: current concepts in chronic pancreatitis

Tattersall SJ, Apte MV, Wilson JS. Intern Med J. July 2008. Vol.38. No.7. p.592-8.
Reviewed by Dr Helen Moriarty

Review: An interesting review of recent advances in understanding of pancreatitis pathogenesis including genetic risks and inflammatory pathways, and natural history. Treatment remains supportive but there is potential to target enzymes and cytokines in future.
Comment: Concise and colourful article, good for a rapid update – how about taking this article along to your peer group?

28–422 Statins and elevated liver tests: what's the fuss?

Onusko E. J Fam Pract. July 2008. Vol.57. No.7. p.449-52.
Reviewed by Dr Bruce Adlam

Review: This review examines the hepatic safety profile of statins and details why there's no need to stop treatment based on moderate elevations in liver function tests. The most common serious side effect of statins – muscle damage/rhabdomyolysis – is rare, and is not extensively discussed in this review. The recommendations are: (a) Order liver function tests before starting statin therapy, 12 weeks after initiation, with any dose increase, and periodically for long-term maintenance therapy (C). (b) Mild elevations of alanine aminotransferase (ALT) or aspartate aminotransferase (AST) (<3 times the upper limit of normal [ULN]) following statin therapy do not appear to lead to significant liver toxicity over time (C). (c) Other medications that lower low-density lipoprotein (LDL), and might be substituted for statins, may not improve morbidity and mortality (C).
Comment: Note that these recommendations are 'Strength of recommendation C' meaning: consensus, usual practice, opinion, disease-oriented evidence, case series.

General

28–423 The art of medicine – taking sensible precautions

Lewens T. Lancet. 14-20 June 2008. Vol.371. No.9629. p.1992-3.
Reviewed by Dr Tony Hanne

Review: This article is part of a thought provoking series on the Art of Medicine designed to make us think outside the square. To illustrate his point that benefit has to be balanced against risk in medical decisions, the author presents his article around a photograph of a workman with no safety equipment, asleep on an exposed, narrow beam on a high rise building site, with his radio at his head and a cigarette in his mouth. All of us agree the risk he runs is sheer foolishness. But is there a middle path? Regulators, the author claims, want to eliminate risk entirely even when they lack evidence to support their policy. Medico-legal threats or the prospect of facing some committee of enquiry motivate such absolute bans on even moderate risk. The result may be a lost opportunity for help which the patient would be willing to take.
Comment: As GPs we often face this kind of situation when a wobbly old person wants to remain in his or her own home but the family want the 'safety' of a rest home, which is probably a more dangerous place.

28–424 Colin Murdoch – obituary

Pincock S. Lancet. 14-20 June 2008. Vol.371. No.9629. p.1994.
Reviewed by Dr Tony Hanne

Review: This short article celebrates the life of a remarkable Kiwi who demonstrated the possibilities of number 8 wire. As a typical New Zealander he lacked the capital to reap the financial rewards of his 46 patents so that most often it was multinational companies who made money out of his brilliant ideas. Among many other inventions he was responsible for the disposable syringe, the child proof bottle cap, the silent burglar alarm and the tranquiliser gun. He accepted the pirating of his inventions with the philosophical observation that 'having a patent gave you the right to sue, but not the money to do so.' In any case he was happy that his inventions were put to good use.
Comment: Interestingly Colin Murdoch was dyslexic which makes

it likely that he also had ADHD. If so, his daydreaming was wonderfully fruitful. Apparently the NZ Department of Health of his day decided that his disposable syringe was 'too futuristic and would not be adopted by medical staff or accepted by patients.' Yeah right!

Geriatrics

28–425 Assessing elderly people to drive – practical considerations

Kamenoff L. Aust Fam Physician. September 2008. Vol.37. No.9. p.727-32.
Reviewed by Dr Mary Tucker

Review: Older drivers are likely to suffer decline in areas of physical and cognitive function. The presence of multiple co-morbidities, as well as associated polypharmacy, may adversely affect the older person's judgement and overall ability to drive safely. The three key factors for safe driving are vision (visual acuity, visual fields and contrast sensitivity), motor function (joint movements – with emphasis on cervical rotation and movements of the shoulder joints, wrists, hips and ankles – motor strength and coordination) and cognition (memory, sensory perception, attention and decision making requiring executive skills). The trail making test and clock drawing tests (both tests of executive function) are useful in assessing ability to drive safely while the MMSE has a low predictive value for safe driving. Information from relatives and neighbours with regard to overall functioning may be helpful.

Comment: This article provides a useful overview of the assessment of fitness to drive with an emphasis on important practical points. Where there is uncertainty with regard to fitness to drive, referral for a practical driving assessment should be made.

Musculoskeletal System

28–426 What are the best treatments for fibromyalgia?

J Fam Pract. July 2008. Vol.57. No.7. p.440.
Reviewed by Dr Bruce Adlam

Review: Antidepressants, tramadol, (pramipexole, pregabalin tropisetron which are not available in NZ), and heated pool treatments provide relief for fibromyalgia pain. Level of evidence = 1a. These guidelines were developed by the European League Against Rheumatism (EULAR), a multidisciplinary task force of representatives from 11 European countries. Strong evidence was available only for drug therapy. Based on a good response in several small trials, the group recommends heated pool treatments with or without exercise (strength of evidence: B). Tramadol, antidepressants, tropisetron, pramipexole, and pregabalin are effective for reducing pain, and antidepressants can improve function (strength of evidence: A). Only weak evidence supports the use of tailored exercise programmes, cognitive behavioural therapy, acetaminophen, or weak opioids. The group recommends against the use of corticosteroids or strong opioids.

Comment: No research has evaluated the relative benefits of treatment, and most of the studies have been short in duration, creating the possibility of a potent placebo effect. (Original article reviewed: Ann Rheum Dis. 2008;67:536-541).

Neurology

28–427 Trigeminal neuralgia

Krafft RM. Am Fam Physician. 1 May 2008. Vol.77. No.9. p.1291-6.
Reviewed by Dr Andrea Steinberg

Review: This overview discusses the proposed clinical identification, aetiology and management options of this most painful condition. Trigeminal neuralgia may involve any or more than one branch of the trigeminal nerve, though the maxillary branch (on the right due to the narrower foramina on that side) is the commonest site. Peak incidence is at 60–70 years of age, and it is commoner in those with MS. It is proposed that demyellination of the nerve is the underlying pathology, possibly as a result of vascular compression. The diagnosis is made clinically, and the classic description of unilateral severe facial pain, triggered by activities such as talking, shaving, even a cool breeze, is well known. A careful search for other causes of the facial pain such as TMJ dysfunction, should be made. Carbamazepine at doses of between 200–800mg per day is the initial management. If unsuccessful, or if only partial relief is obtained, other medications that have been used include baclofen, penytoin, lamotrigine, gabapentin, topiramate, clonazepam, and valproic acid. Various surgical procedures are available, and microvascular decompression seems to be the most effective.

Comment: One should continue to be aware of this as a differential in the diagnosis of facial pain, even though the average GP may only see a handful of cases in his/her working life.

28–428 Update on managing Bell's palsy

Drug Ther Bull. July 2008. Vol.46. No.7. p.53-4.
Reviewed by Fiona Corbin

Review: According to this bulletin the evidence suggests oral prednisolone (50mg daily for 10 days) started within 72 hours of symptoms onset makes recovery from Bell's palsy more likely. However evidence supporting use of antiviral drugs, acupuncture or physiotherapy in this condition is not convincing.

Comment: This is a short bulletin which provides a succinct review of recently published evidence relating to drug, acupuncture and physiotherapy treatments for Bell's Palsy.

28–429 Is osteopathic manipulation effective for headaches?

Keays AC, Neher JO, Safranek S. J Fam Pract. March 2008. Vol.57. No.3. p.190-1.
Reviewed by Dr Bruce Adlam

Review: It can be. Spinal manipulative therapy (SMT), a component of osteopathy, has been shown to be variably effective for the treatment

of headaches. For the prophylactic treatment of cervicogenic headaches and for acute tension headaches, SMT is superior to placebo. For tension headache prophylaxis, research shows a trend toward better outcomes with amitriptyline than with SMT. For migraine prophylaxis, SMT has an effect similar to amitriptyiline (strength of recommendation: B)

28–430 Recognition of obstructive sleep apnea and associated excessive sleepiness in primary care

Doghramji PP. J Fam Pract. August 2008. Vol.57. No.8. p.S17-23.

Reviewed by Dr Bruce Adlam

Review: Quite an interesting article which suggests by being aware of the symptoms, predisposing factors, and co-morbidities associated with obstructive sleep apnoea (OSA), primary care providers can play a vital role in screening their patients for OSA (SOR: C).

Comment: There is a good differential diagnosis of excessive sleepiness and risk factors.

Nutritional and Metabolic Diseases

28–431 Surgery for obesity in adults

Drug Ther Bull. June 2008. Vol.46. No.6. p.41-5.

Reviewed by Fiona Corbin

Review: Various bariatric surgery options and the place of these in the management of adults with obesity are reviewed. The most commonly used bariatric surgical procedures, according to this UK-based review, are gastric restrictive operations (including laproscopic adjustable gastric banding), malabsorptive operations (including biliopancreatic diversion), and surgery combining restrictive and malabsorptive approaches (e.g. Roux-en-Y gastric bypass). The article reviews and compares clinical efficacy and unwanted effects of the various different procedures. Bariatric surgery has also been found to be relatively cost effective compared to conventional treatment in morbid obesity for achieving long-term weight loss and improving quality of life and co-morbidities by a NHS Health Technology Assessment appraisal.

Comment: It is estimated that in New Zealand 60% of the population is overweight and 20% is obese. Similar to trends in other first world countries these statistics are on the increase along with associated morbidity and resulting premature death. As a result procedures such as laproscopic adjustable gastric banding are becoming increasingly accessible and performed. This review provides a useful and succinct review of the 'state of the art' of bariatric surgery.

28–432 Raised CRP levels in obese patients: symptoms of depression have an independent positive association

Dixon JB, Hayden MJ, Lambert GW, et al. Obesity. September 2008. Vol.16. No.9. p.2010-5.

Reviewed by Dr Anne-Thea McGill

Review: This was a large study (493 consecutive patients) of participants (BMI 30–91kg/m-2, age 14–71, 76% women) presenting for bariatric surgery. The inflammatory protein C- reactive protein (CRP) was related (using various regression models) with co-morbidities or conditions of obesity, including depression assessed by the Beck Depression Inventory. The results in order of strength of association, were: higher BMI (ß = 0.36, P < 0.001), female gender (ß = -0.19, P < 0.001), oestrogen therapy (ß = 0.18, P < 0.001), higher BDI score (ß = 0.11, P = 0.01), and insulin resistance index (ß = 0.11, P = 0.01), and with a combined R2 = 0.24, (P < 0.001).

Comment: The new revelation was that depression was related. With ¾ of the group being female, and being female and oestrogens known to be related to higher CRP levels (and at least one study indicating the CRP is made in the fat) and the mean depression score being moderate depression (only 26% not depressed at all) and most depression occurring in women, however, perhaps this result is to be expected. Past studies have related raised CRP to CVD risk, which is usually lower in women. Indeed, our study (in revision) showed CPR to be less related to metabolic risk than other serum markers. I would watch for depression in the obese, and not measure CRP for CVD risk.

28–433 Distribution of subcutaneous fat predicts insulin action in obesity in sex-specific manner

Koska J, Stefan N, Votruba SB, et al. Obesity. September 2008. Vol.16. No.9. p.2003-9.

Reviewed by Dr Anne-Thea McGill

Review: This study is a very detailed study of body fat (intra-abdominal, subcutaneous abdominal, deep and superficial, and femoral) compartments and glucose uptake in cells (insulin mediated) and liver suppression of glucose. It was done in 57 (35 men) young (18–45, mean 25 years) Pima men and women with raised body fat percentage >25% men >30% women (obese) with normal glucose tolerance. The researchers used MRI scanning and glucose clamps.

Comment: Expected findings were that increased intraperitoneal or visceral and deep subcutaneous abdominal fat accumulation was a negative predictor of insulin effect in men and women. However, higher abdominal subcutaneous (deep and superficial) and low thigh fat had glucose metabolism problems in women, and for men the worse combination were increased deep subcutaneous and minimal superficial fat depots. These findings may be ethnic specific but tie in with previous studies where they have been done in this detail. We need all the early clinical predictors of serious metabolic disease that are easy to use. Fat distribution is one.

Oncology

28–434 Management of depression for people with cancer (SMaRT oncology 1): a randomised trial

Strong V, Waters R, Hibberd C, et al. Lancet. 5-11 July 2008. Vol.372. No.9632. p.40-8.

Reviewed by Dr Tony Hanne

Review: The purpose of this trial was to establish whether nurse-led counselling support of cancer patients, in whom depression had been identified by the use of a depression rating checklist, could improve their care. The nurses did not have previous psychiatric qualification or experience but were trained for this programme. They taught coping strategies. Decisions about whether to use antidepressants were left to the patients' GP or psychiatrist. The supported patients did significantly better than those who received only usual care. Both groups had a higher rate of depression treatment than is usual in cancer patients simply because depression had been looked for and found.

Comment: The result of this trial should be no surprise. What is not clear is whether the benefit was due to the specifics of the counselling programme or simply due to the fact that someone was designated to care about the emotional impact of a diagnosis of cancer. Oncologists as much as any specialty group can easily overlook diagnoses such as depression which are outside their specialist territory. All of us need to be reminded that high-tech medicine can never replace sympathetic care which our patients hope for from us more than anything else.

Paediatrics

28–435 Approach to milk protein allergy in infants

Brill H. Can Fam Physician. September 2008. Vol.54. p.1258-64.

Reviewed by Dr Mike Lyons

Review: Deals with clinical presentation differentiating between IgE and Non IgE mediated, diagnosis (states a combination of skin prick testing and IgE antibody measurement gives a positive predictive value of 95% in IgE mediated cow's milk protein allergy), management and prognosis. Breast-feeding can continue with education about exclusions from a dietitian. Formula-fed infants need extensively hydrolysed protein formulas and amino acid based formulas – both expensive options. Milk protein substitution (e.g. soya or goat) is not an option due to cross sensitivity of milk protein causing intestinal enteropathy which further increases the likelihood of greater cross sensitisation. The timing of milk protein reintroduction, a table of when to refer, and an algorithm round off the short article.

Comment: Read in conjunction with *Best Practice* issue 15 in August 2008 article 'Infant formula' (see 28-436).

28–436 Infant formula

Cormack B. Best Pract. August 2008. No.15. p.26-31.

Reviewed by Dr Mike Lyons

Review: See 28-435.

28–437 Paracetamol plus Ibuprofen for the treatment of fever in children (PITCH): randomised controlled trial

Hay AD, Costelloe C, Redmond NM, et al. BMJ. 2 September 2008. Vol.337. p.a1302 (9 pages)

Reviewed by Dr Len Brake

Review: There is no evidence that reducing temperature shortens the duration of illness or reduces complications such as febrile convulsions. In fact as the editor of the *BMJ* reminds us, reducing the fever may prolong the illness. Then hovering in the background are the spectres of increased soft tissue infection with ibuprofen, paracetamol over-dosage and liver damage, and the effect of antipyretic medication on airways constriction. Nevertheless the power of the people overcomes the rules of evidence-based medicine again and the use of antipyretics is widespread. It is not until the 3rd page that the authors mention the disappointingly low recruitment sample (n=156). About 50 into each of the three groups paracetamol, ibuprofen and combination. There is no group using a non-drug approach. The outcomes include time without fever in the first four hours, and the even more nebulous *'proportion of children reported as being normal on the discomfort scale at 48hrs.'*

Comment: The conclusion is that if one wants to uses drugs to lower the fever in an unwell child start with ibuprofen then consider there relative risks of using the combination paracetamol plus ibuprofen over a 24 hour period.

Palliative Care

28–438 Palliative care research in the community: it is time to progress this emerging field

Palliat Med. July 2008. Vol.22. No.5. p.609-11.

Reviewed by Dr Peter Woolford

Review: This editorial is a recognition of the hugely important and pivotal role that primary care plays in palliative care even though the emergence of specialist hospice care has *'disempowered some primary care providers and led to a belief that only specialist palliative care can provide "proper palliative care".'* It goes on to state that it *'must be remembered and acknowledged that the vast majority of palliative care is carried out within primary care multidisciplinary teams, who are also very well placed to provide support to those families that require it after the death of the patient.'* It goes on to make a plea for more primary palliative research and gives some pointers.

Comment: Is there anybody out there interested in general practice palliative care research? Ring me if you are!

28–439 Differing management of people with advanced cancer and delirium by four sub-specialties

Agar M, Currow DC, Plummer J, et al. Palliat Med. July 2008. Vol.22. No.5. p.633-40.

Reviewed by Dr Peter Woolford

Review: Delirium is present in palliative patients in the order of 28–48%. Maintaining lucidity at the end of life has been identified by patients and families to be as important as pain control. This study asks four different subspecialties (oncologists, psychogeriatricians, geriatricians and palliative medicine specialists) how they manage delirium and, surprise, surprise, there were significant dif-

ferences between the groups. Differences in what investigations they might undertake as well as where they might care for the patient (home or hospital) and what treatments they would use.

Comment: I always find delirium in the palliative setting a difficult area. It is important to rule out reversible causes (for example, infection, hypercalcaemia, hypoxia, dehydration) as appropriate, and then treat the symptoms as expeditiously as possible. To my way of thinking using neuroleptics (traditionally haloperidol or more recently methotrimeprazine) are first line in the pharmacological management, with benzodiazepines coming up the rear. This was not the case for a number of the doctors, and some even offered opioids as first choice for terminal sedation, even when it was not a choice in the study. This demonstrated for me the tricky nature of the assessment and treatment of delirium in the dying phase, but also that I thought that I would stick to my tried and true, sort of research based, but probably more anecdotal, approach until there is more evidence available.

28–440 Inappropriateness of using opioids for end-stage palliative sedation: a Dutch study

Reuzel RP, Hasselaar GJ, Vissers KC, et al.
Palliat Med. July 2008. Vol.22. No.5. p.641-6.
Reviewed by Dr Peter Woolford

Review: In the Netherlands there is currently intense public debate about whether end stage palliative sedation is a method of symptom control or a method of 'hidden' or 'slow' euthanasia. (Euthanasia is legal in the Netherlands). A large number of GPs, medical specialists and nursing home physicians were surveyed. The underlying assumption here was that the use of opioids alone in this situation is less appropriate than other medications. The literature suggests that benzodiazepines should be used in conjunction with an opiod.

Comment: This was interesting being published in the same issue as the preceding paper, and again highlights the differences in clinical practice at the coal face. The GPs surveyed were doing significantly better in this area than hospital colleagues when benchmarked against the protocols for palliative sedation. This paper has an interesting discussion and is worthwhile having a read.

Physician–Patient Relations

28–441 A morally reprehensible patient

Schonfeld TL, Damitz BA. Am Fam Physician.
1 April 2008. Vol.77. No.7. p.1020-3.
Reviewed by Dr Andrea Steinberg

Review: This is a frank exploration of the distress of a family physician who began to find that his 'dislike' of a patient turned into 'frank aversion.' This was due to such dissonance in the views held by the patient that it transcended the ability of the physician to deal as he usually did, with the common conflicts of value that faced him in everyday practice. The author bravely explores the issues around these behaviours of both patient and physician, and concludes that the real problem may have been *'related to the physician's expectations of patient behaviour.'*

Comment: This will strike a chord in the hearts of all of us, and asks the *'question of what it means to say that all patients deserve competent, compassionate care.'*

Prescribing

28–442 Inappropriate prescribing in the older population: need for new criteria

O'Mahony D, Gallagher PF. Age Ageing.
March 2008. Vol.37. No.2. p.138-41.
Reviewed by Fiona Corbin

Review: This is a commentary written by two authors of a paper published in the previous issue of *Age & Ageing*. The previous paper described a study to determine the prevalence of potentially inappropriate prescribing in a population of elderly patients using Beer's criteria. This commentary considers available, validated screening tools for detecting inappropriate prescribing in the elderly. The authors consider the deficiencies in currently available tools and suggest that new screening criteria are required that are comprehensive, user-friendly and evidence-based.

Comment: The paper provides a useful and interesting critique of Beers' Criteria which have dominated the literature on measuring inappropriate prescribing since they were first described in 1991.

Preventive Medicine and Screening

28–443 Screening and brief interventions for alcohol: attitudes, knowledge and experience of community pharmacists in Auckland, New Zealand

Sheridan S, Wheeler A, Chen LJ-H, et al.
Drug Alcohol Rev. July 2008. Vol.27. No.4.
p.380-8.
Reviewed by Dr Helen Moriarty

Review: A postal survey of community pharmacists achieved 39% response rate after three mailshots. The survey asked about pharmacist knowledge of alcohol drink content and recommended limits. Responders were motivated but had poor knowledge of and confidence in tackling the topic with customers. A follow up on 10% of non-responders found similar attitudes but even lower knowledge levels. The authors state that this is a field in which community pharmacists can greatly contribute to population health, but has been overlooked.

Comment: GPs – can you talk to your pharmacist about their confidence in raising the topic with local customers?

Primary Health Care

28–444 A renaissance in primary health care – editorial

Lancet. 13-19 September 2008. Vol.372.
No.9642. p.863.
Reviewed by Dr Tony Hanne

Review: Most of this issue of the *Lancet* is devoted to Primary Health Care in recognition of the 30th anniversary of the Alma-Ata Declaration in which 134 countries set the ambitious goal of 'Health for all by 2000'. Like almost all international declarations which are long on rhetoric but short on commitment to the means of achieving them, Alma-Ata failed. The dream has been derailed by new diseases like HIV/AIDS, by conflict, by 1.4 billion people still living in poverty, by a lack of trained health workers in the right places, and by corruption and greed. But some countries like Thailand, Cuba, Malawi and Haiti have achieved remarkable progress despite all these things. We can learn from them.
Comment: This editorial introduces a number of research articles and a series of eight reviews of aspects of the challenge of what can be achieved when Primary Care has good training, wise planning, adequate resources and above all high ethics and morale. Alma-Ata, it is suggested, is not dead! We too in NZ have much to learn.

28-445 Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise (Alma-Ata: rebirth and revision 1)
Lawn JE, Rohde J, Rifkin S, et al. Lancet. 13-19 September 2008. Vol.372. No.9642. p.917-27.
Reviewed by Dr Tony Hanne
Review: The first in a series of eight articles (See 28-446 to 28-452 below) which revisit, 30 years on, the principles of the Alma-Ata Declaration, and examine the changes that have taken place since then, the new challenges which face primary health care and a look at possible futures and solutions. While many good things have happened there are two significant weaknesses, the failure to achieve real community consultation and participation, and the lack of intersectoral cooperation between the different agencies which impact on health.
Comment: Many of the themes explored in the eight articles are just as relevant for 'rich' countries as for 'poor' and there are lessons to be learned from countries which have primary health care delivery systems which appear alien to ours. The same weakness identified in developing countries occur in developed countries such as NZ where DHBs do not really listen to the grass roots in their communities or even to other government agencies such as those concerned with housing or welfare. For those who have thought deeply about primary health care there is much in these articles which will be familiar but it is rare to find the material brought together in one place, and, of course, there are surprises.

28-446 Supporting the delivery of cost-effective interventions in primary health-care systems in low-income and middle-income countries: an overview of systematic reviews (Alma-Ata: rebirth and revision 2)
Lewin S, Lavis JN, Oxman AD, et al. Lancet. 13-19 September 2008. Vol.372. No.9642. p.929-39.
Reviewed by Dr Tony Hanne
Review: See 28-445 above.

28-447 Improving the prevention and management of chronic disease in low-income and middle-income countries: a priority for primary health care (Alma-Ata: rebirth and revision 3)
Beaglehole R, Epping-Jordan J, Patel V, et al. Lancet. 13-19 September 2008. Vol.372. No.9642. p.940-9.
Reviewed by Dr Tony Hanne
Review: See 28-445 above.

28-448 30 years after Alma-Ata: has primary health care worked in countries? (Alma-Ata: rebirth and revision 4)
Rohde J, Cousens S, Chopra M, et al. Lancet. 13-19 September 2008. Vol.372. No.9642. p.950-61.
Reviewed by Dr Tony Hanne
Review: See 28-445 above.

28-449 Community participation: lessons for maternal, newborn, and child health (Alma-Ata: rebirth and revision 5)
Rosato M, Laverack G, Grabman LH, et al. Lancet. 13-19 September 2008. Vol.372. No.9642. p.962-71.
Reviewed by Dr Tony Hanne
Review: See 28439 above.

28-450 Interventions to address maternal, newborn, and child survival: what difference can integrated primary health care strategies make? (Alma-Ata: rebirth and revision 6)
Bhutta ZA, Ali S, Cousens S, et al. Lancet. 13-19 September 2008. Vol.372. No.9642. p.972-89.
Reviewed by Dr Tony Hanne
Review: See 28-445 above.

28-451 Integrating health interventions for women, newborn babies, and children: a framework for action (Alma-Ata: rebirth and revision 7)
Ekman B, Pathmanathan I, Liljestrand J. Lancet. 13-19 September 2008. Vol.372. No.9642. p.990-1000.
Reviewed by Dr Tony Hanne
Review: See 28-445 above.

28-452 Primary health care: making Alma-Ata a reality (Alma-Ata: rebirth and revision 8)
Walley J, Lawn JE, Tinker A, et al. Lancet. 13-19 September 2008. Vol.372. No.9642. p.1001-7.
Reviewed by Dr Tony Hanne
Review: See 28-445 above.

28-453 Return to Alma-Ata
Chan M. Lancet. 13-19 September 2008. Vol.372. No.9642. p.865-66.
Reviewed by Dr Tony Hanne
Review: Comment on an article (See 28-454 below) outlining the implementation and outcome of a community-based primary health worker intervention for mothers with depression in rural Pakistan. In Pakistan, as in most countries, depression is both under diagnosed and under treated.
Comment: With many developed countries, such as New Zealand, faced with a chronic shortage of mental health care specialists, and lacking the resources to train sufficient to fill the gaps, there are implications from

this study for the treatment of common mental disorders. Whether we have a mental health care system which could adapt to such changes, or has the political will to do so, is another question.

28-454 Cognitive behaviuour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised controlled trial

Rahman A, Malik A, Sikander S, et al. Lancet. 13-19 September 2008. Vol.372. No.9642. p.902-9.

Reviewed by Dr Tony Hanne

Review: See review 28-453 above.

Psychiatry and Psychology

28-455 Do dementia treatments improve symptoms or delay progression?

J Fam Pract. July 2008. Vol.57. No.7. p.441-2.

Reviewed by Dr Bruce Adlam

Review: No. Although they produce a statistical improvement when compared with placebo, neither cholinesterase inhibitors nor memantine produce clinically noticeable effects on cognition, behaviour, or quality of life. No study was long enough to note a slowing of decline of functioning. Level of evidence = la. Five pharmacologic therapies are marketed for treating dementia, specifically Alzheimer disease. When all the studies were pooled by individual drug, donepezil was statistically more effective than placebo when all levels of severity were included, but was not effective for patients with mild cognitive impairment. Galantamine and rivastigmine were more effective than placebo, and memantine was more effective only for patients with mild to moderate vascular dementia.

Comment: None of the results was clinically relevant, averaging less than three points on the ADAS-cog scale. There was even less of a consistent effect on behaviour and quality of life. Most of the studies were of short duration and, therefore, we don't know whether any of the drugs will delay progression of the disease. (Original article reviewed: Ann Intern Med. 2008;148:379-397)

Research Design and Methodology

28-456 Test for equivalence or non-inferiority - why?

Drug Ther Bull. July 2008. Vol.46. No.7. p.55-6.

Reviewed by Fiona Corbin

Review: This paper examines equivalence or non-inferiority trials. These types of trials, particularly non-inferiority trials, are increasingly used instead of superiority trials to test new drugs.

Comment: A short but useful article that 'deconstructs' equivalence and non-inferiority trials including potential problems to watch out for when reading reports describing such trials. A checklist of questions to consider when appraising these types of trials is provided.

Respiratory System

28-457 Approach to chronic obstructive pulmonary disease in primary care

Todd DC, McIvor RA, Pugsley SO, et al. Can Fam Physician. May 2008. Vol.54. p.706-11.

Reviewed by Dr Mike Lyons

Review: Emphasises the progressive nature of the respiratory and systemic debility of COPD. States all smokers and ex-smokers 40 years and older should be screened by their GP with office spirometry – an underutilised tool. Says up to 19% will be picked up and 40% of those will already have moderate to severe impairment in lung function. Following diagnosis, assessment is made to identify contributing factors, quantify effects on daily living and give a prognosis. A BODE score is calculated from body mass index, spirometry, a six minute walk test and evaluation of a modified medical research council dyspnea scale. Management includes education, pulmonary rehabilitation, short and long acting bronchodilators and selective use of inhaled steroids. Cor pulmonale, respiratory acidosis, osteoporosis and depression may need additional support. A 7–10 course of Prednisone is recommended for exacerbations routinely - unless there is a genuine contraindication. Antibiotics are less used and only in infective exacerbations. Annual influenza vaccination is a sine qua non.

Comment: Office spirometry is the key cornerstone to start the process. My office screening COPD – six made by Vitalograph in Ennis Ireland has proved a useful tool on my desk but the nurses need to follow up positive results with a 45 minute formal spirometry that some patients baulk at paying for!

Rheumatic Diseases

28-458 Oral prednisolone and naproxen: equally effective for acute gout?

J Fam Pract. September 2008. Vol.57. No.9. p.576.

Reviewed by Dr Bruce Adlam

Review: Oral prednisolone and naproxen are equivalent in treating patients with acute gout. Level of evidence = 1b. Colchicine, has a narrow therapeutic window and cannot be used in patients with kidney failure. Nonsteroidal anti-inflammatory drugs (NSAIDs) are problematic, especially in the elderly. Oral steroids are an attractive potential alternative because the short-term side effects are fairly mild. Patients were randomly assigned to receive prednisolone 35mg once daily or naproxen 500mg twice daily. Both treatments provided significant pain relief and no significant difference was noted in pain improvement or impairment between the two groups. Approximately two-thirds of patients in each group reported no treatment side effects. The rate of side effects was identical in each group for gastric or abdominal pain (15%), itching or dizziness (7%), and dyspnea

or palpitations (5%). Approximately 20% in each group experienced 'other side effects.' By three weeks, all patients reported complete relief from the initial attack, and no patients had a recurrence. (Original article reviewed: Lancet. 2008; 371:1854-1860)

Smoking

28-459 What does it mean to want to quit?

Balmford J, Borland R. Drug Alcohol Rev. January 2008. Vol.27. No.1. p.21-7.
Reviewed by Dr Helen Moriarty

Review: The Cancer Council of Victoria commissioned a community-based telephone survey of current or recent adult smokers to explore attitudes and beliefs about wanting to quit and accepting help to do so. Likert scale answers were requested to statements such as 'to quit successfully you really have to want to, then you'll just do it' and 'I am too addicted to be able to quit.' Since attitude can be influenced by stages in the motivational cycle, the data was stratified according to those who had just quit or were thinking about it or not. Thirty-four per cent of the 802 participants thought they were too addicted to stop smoking. Forty-two per cent of those in pre-contemplation agreed to the statement that quit aids were 'a sign of weakness, if you really want to quit you will be able do it by yourself.'

Comment: As this last statement illustrates, many of the questions had more than one stem, a flaw that means that different possible responses to each stem within the one question couldn't be captured. The Likert scale of responses also seemed superfluous as the gradation of responses were not commented upon at all! Given all of this one would not want to read too much into the conclusion except to agree that we still need greater understanding of a smoker's ambivalence to quit.

28-460 Update on pharmacologic and nonpharmacologic therapies for smoking cessation

Schmelzle J, Rosser WW, Birtwhistle R. Can Fam Physician. July 2008. Vol.54. p.994-9.
Reviewed by Dr Mike Lyons

Review: Discusses success rates at six months and side effects of Nicotine replacement therapies, Bupropion (Zyban), Varenicline (Champix), individual and group counselling and combined therapies.

Comment: Preliminary data suggests that Champix is the most effective treatment BUT – study limitations of industry funding, wide exclusion criteria and greatly different losses to follow up between groups, affect the reliability of results and would make cautious clinicians await independent verification (or rejection) studies.

Speech Disorders

28-461 Stuttering: an overview

Prasse JE, Kikano GE. Am Fam Physician. 1 May 2008. Vol.77. No.9. p.1269-76.
Reviewed by Dr Andrea Steinberg

Review: Speech dysfluency, or stuttering, may occur in any age group, but is more common in young children, where it is present in around 1.4% of children under 10 years of age. Most resolves by adulthood. 80% of those in whom it persists into adulthood are men. Developmental stuttering is the commonest form, and usually resolves spontaneously, but may progress to associated secondary behaviours. Neurogenic stuttering may follow an acute neurological event. Psychogenic stuttering, with rapid repetition of initial sounds, is rare and usually occurs in association with other psychiatric illnesses. Aetiology of stuttering is still essentially unclear, but growing evidence and the preponderance in boys/men supports a genetic component. The social burden is significant, and there is a lack of evidence about efficacy of current therapy – there is no effective medication. Current speech language therapy is focused on the prevention of progression in children, and the family plays an important role in management. The likelihood of effective therapy decreases if the stuttering persists beyond eight years of age.

Comment: A debilitating and frustrating problem which is likely to be presented to the GP first. (Patient information handout included).

Sports and Exercise Medicine

28-462 Walking or vitamin B for cognition in older adults with mild cognitive impairment? a randomised controlled trial

van Uffelen JG, Chinapaw MJ, van Mechelen W. Br J Sports Med. May 2008. Vol.42. No.5. p.344-50.
Reviewed by Dr Chris Milne

Review: This RCT randomly assigned 152 participants to a twice weekly group based moderate intensity walking programme or a daily vitamin tablet containing 5mg folic acid, 0.4mg vitamin B12 and 50mg of vitamin B6. Results showed neither group had improved cognitive function but the walking group had improved memory.

Comment: Yet another reason to go for a good walk.

28-463 Preventing sports injuries at the national level: time for other nations to follow New Zealand's remarkable success

Orchard JW. Br J Sports Med. 1 Jun 2008. Vol.42. No.6. p.392-3.
Reviewed by Dr Chris Milne

Review: This editorial documents the effects of ACC injury prevention programmes in several areas – catastrophic spinal injury in rugby (reduced by 50 %), dental injury in contact sports (substantially reduced by mouthguard usage). The costs of the prevention programmes have been shown in most cases to be cheaper than the direct and indirect costs for the injuries prevented.

Comment: Having travelled extensively and talked with clinicians from many countries, I'm not sure that we appreciate how much the ACC scheme has achieved.

28–464 Non-contact ACL injuries in female athletes: an International Olympic Committee current concepts statement

Renstrom P, Ljungqvist A, Arendt E, et al. Br J Sports Med. 1 June 2008. Vol.42. No.6. p.394-412.

Reviewed by Dr Chris Milne

Review: Female athletes are at two to three times greater risk of ACL rupture that male athletes. Risk factors include the pre-ovulatory phase of the menstrual cycle, decreased width of the intercondylar notch and faulty landing technique (landing with a straight knee is risky).

Comment: This is a comprehensive, state-of-the art paper with 147 references. The 18 authors are respected experts from many major world centres of excellence.

28–465 Interim evaluation of the effect of a new scrum law on neck and back injuries in rugby union

Gianotti S, Hume PA, Hopkins WG, et al. Br J Sports Med. 1 Jun 2008. Vol.42. No.6. p.427-30.

Reviewed by Dr Chris Milne

Review: This paper reviews the experience following the introduction of the new IRB law on scrum engagement. The predicted ACC claims per 100,000 forwards was 76. In the event, only 52 claims per 100 000 were lodged, which is heartening.

Comment: Although it's early days, these results tend to suggest that the new laws for scrum engagement will prevent injury.

28–466 Testing for maximum oxygen consumption has produced a brainless model of human exercise performance

Noakes TD. Br J Sports Med. 1 July 2008. Vol.42. No.7. p.551-5.

Reviewed by Dr Chris Milne

Review: The author Professor Tim Noakes is well known for his views on this topic. He has proposed an elegant model where the brain anticipates the exercise level required to complete an exercise bout, and sets the pace at which the body can move without catastrophic metabolic collapse.

Comment: This is a compelling article which will be of interest to those doctors who think that sports performance is more than how fast you can run on a treadmill.

28–467 Screening the athlete's shoulder for impingement symptoms: a clinical reasoning algorithm for early detection of shoulder pathology

Cools AM, Cambier D, Witvrouw EE. Br J Sports Med. 1 August 2008. Vol.42. No.8. p.628-35.

Reviewed by Dr Chris Milne

Review: Shoulder impingement is common. Most of this relates to the rotator cuff, and there is often associated mild instability. This article describes a detailed algorithm that can help the clinician improve their diagnostic accuracy.

Comment: No single test is perfect, but this article presents the most detailed evaluation that you could wish for. Photographs of particular clinical tests (e.g. Hawkins impingement test) are a special bonus.

Therapeutics

28–468 Rituximab and abatacept for rheumatoid arthritis

Drug Ther Bull. August 2008. Vol.46. No.8. p.57-61.

Reviewed by Fiona Corbin

Review: This article reviews the available trial evidence and possible place in management of rheumatoid arthritis for rituximab and abatacept – immunosuppressant drugs in two new classes.

Comment: Rituximab is licensed in New Zealand for treatment of lymphomas and rheumatoid arthritis. It is funded under Special Authority for use in lymphomas and also post transplant but not for rheumatoid arthritis.

28–469 Meeting the challenge of antibiotic resistance

Cars O, Högberg LD, Murray M, et al. BMJ. 18 September 2008. Vol.337. p.a1438 (3 pages)

Reviewed by Dr Len Brake

Review: Apart from the lack of effective treatment for infectious diseases exemplified by the rise in deaths from MRSA to give one example, there is the likelihood that 'we risk rolling back achievements such as organ transplants, major surgery and cancer chemotherapy' without effective treatment of bacterial infections. Development of new antibiotics is declining. More than a dozen new classes of antibiotics were developed in the mid 20th century. Only two classes have been developed since then. Only 1.6% of drugs in development today are antibiotics – none of them novel classes. Professor Cars puts forward the paradigm where antibiotics are considered as a non-renewable resource. He intimates that 'the patient's choice' to use an antibiotic will make it possible that another person might die, as all use of an antibiotic, appropriate or not, 'uses up' some of the effectiveness of that antibiotic.

Comment: The glaring problem will be that the truckloads of antibiotics used by large scale meat producers will continue and young caring parents will feel guilty using a single course of antibiotics on little Chloe's otitis media. So good try Otto, but the concept needs work.

Urology

28–470 Detecting chronic kidney disease in older people; what are the implications?

Roderick PJ, Atkins RJ, Smeeth L, et al. Age Ageing. March 2008. Vol.37. No.2. p.179-86.

Reviewed by Fiona Corbin

Review: This paper describes a post-hoc analysis of baseline data from a larger cluster randomised trial of health and social assessment of older people in the community in Great Britain. The objectives of the current analysis were; to determine the frequency of chronic kidney disease (CKD) in older people using glomerular filtration rate estimated

by the Modification of Diet in Renal Disease (MDRD) equation, and to determine associations of CKD with various morbidity and functional measures. The analysis demonstrated that over half the older people (aged 75 years and older) in the original trial had an eGFR < 60 (defined as stage 3–5 CKD). Also, not really surprisingly, that more severe degrees of CKD were more strongly associated with certain co-morbidities and treatment (including cardiovascular co-morbidity and associated medications such as aspirin), functional and cognitive impairment and potentially reversible consequences of loss of kidney function, e.g. anaemia.

Comment: Based on the results of this analysis, the authors suggest that classification of an eGFR < 60 in older people may be too broad for clinical purposes and that the threshold for active identification and intervention for CKD should be re-considered in older people (in the UK context). Lesser degrees of CKD classified according to eGFR were demonstrated in over half of the older population in the study. This would have significant implications on the health care workload required to manage it.

28–471 Association between waist-to-hip ratio and chronic kidney disease in the elderly

Chou C-Y, Lin C-H, Lin C-C, et al. Intern Med J. June 2008. Vol.38. No.6a. p.402-6.

Reviewed by Dr Helen Moriarty

Review: A voluntary health check of 948 Taiwanese participants at a University Hospital correlated anthropomorphic indices with CRF, hypertension and diabetes. Mean age was 66.7 yrs ± 5.1 years. The waist-hip ratio (>0.88) was better than other obesity measurements at predicting kidney disease, but it didn't correlate with hypertension or diabetes or metabolic syndrome. Waist-height ratio also correlated with kidney disease but not as strongly. BMI appears not to be as good a predictor of kidney disease. The rationale might be that waist and hip ratio is a measure of central obesity, but if so the ability to also predict metabolic syndrome is not as expected.

Comment: How often do GPs measure waist circumference? Hip circumference? Calculate BMI? The age range under study here would be called late middle age in NZ, rather than elderly.

Vaccination and Vaccines

28–472 Post-influenza vaccine chronic inflammatory demyelinating polyneruopathy

Brostoff JM, Beitverda Y, Birns J. Age Ageing. March 2008. Vol.37. No.2. p.229-30.

Reviewed by Fiona Corbin

Review: As the title suggests this reports describes a case of chronic inflammatory demyelinating polyneuropathy attributed to influenza vaccination in a 74-year-old man with no prior neurological history.

Comment: This is an interesting case report about a rare complication of a commonly used health care intervention.

Virus Diseases

28–473 Treatment of herpes zoster

Opstelten W, Eekhof J, Neven AK, et al. Can Fam Physician. March 2008. Vol.54. p.373-7.

Reviewed by Dr Mike Lyons

Review: Reviews the evidence of the effect of antiviral therapies and steroids on the severity of acute pain and duration of skin lesions. Also deals with their effect on post herpetic neuralgia - PHN

Comment: I was going to advise if you had a burning (neuralgic) desire to know the answers to send for a copy of the article. I relent as the powers have changed the format of the journal and deem our reviewing services redundant. Antiviral treatment and steroids both have minimal effect on pain severity, antivirals alone slightly reduce the duration of skin lesions and there is no convincing evidence that either treatment makes any difference to PHN – and in the same ineffective boat is amitriptyline as well as cutaneous and percutaneous interventions. However, don't let science get in the way of your favoured management for your Golden Oldies!

Journal of Primary Health Care

Aim and scope

The *Journal of Primary Health Care* (*JPHC*) is a peer-reviewed journal designed to meet the information needs of New Zealand (NZ) general practitioners, practice nurses and community pharmacists plus other primary health care practitioners and the patients and communities we serve. In line with the NZ Primary Health Care Strategy, the scope encompasses general practice, primary health care nursing and community pharmacy. The content is multi-disciplinary and includes papers on Maori, Pacific and Asian health issues, health care delivery, health promotion, epidemiology, public health and medical sociology of interest to a primary health care provider audience.

The journal publishes peer-reviewed quantitative and qualitative original research, systematic reviews and papers on improving performance that are relevant to its primary health care practitioner audience. The journal is a means both of moving research into practice and practice into research.

JPHC acts as a knowledge refinery to provide busy practitioners with up-to-date knowledge about the latest evidence and best practice. Continuing professional education includes pithy summaries of the latest evidence such as Cochrane Corner, POEMS (Patient Oriented Evidence that Matters), brief synopses of guidelines and bulletins, and PEARLS (Practical Evidence About Real Life Situations).

Evidence can help inform best practice. However, sometimes there is no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. Evidence needs to be placed in context. General practice is an art as well as a science. Quality of care lies also with the nature of the clinical relationship, with communication and with truly informed decision-making. The *JPHC* will publish viewpoints, commentaries and reflections that explore areas of uncertainty, of ethics, of aspects of care for which there is no one right answer. Debate is stimulated by the Back to Back section where two professionals present their opposing views on a topic. Letters to the Editor are also welcomed.

JPHC (replacing the *New Zealand Family Physician*) is the official peer-reviewed journal of the RNZCGP from 2009.

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JPHC is published quarterly in March, June, September and December. All original research and improving performance papers are submitted to reviewers before being accepted for publication, and are published as soon as space permits. Papers in press may be published electronically on the website (http://www.rnzcgp.org.nz/journal-of-primary-health-care/) prior to publication of the hard copy issue.

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Times Roman or Arial font, 12 point, double-spaced, 2.5 cm margins. Please do not justify right margin. Number all pages consecutively starting with the title page.

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Use acronyms sparingly. Place abbreviations in brackets after the first appearance of the term in the abstract and again after the first use in the text. Use International System (SI) of units throughout.

Use generic names for drugs. Where a brand name is also used, start with capital letter. Headings: Use the following hierarchy – BOLD UPPER CASE, Bold, Bold italics, Italics, Underlined.

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Follow specific instructions for quantitative, qualitative, or systemic review papers. Short reports follow the same format but are limited to 1000 to 1500 words.

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Please summarise in two short sentences what was already known about the topic and two short sentences about what your work has added to the body of knowledge, with particular relevance to primary health care practitioners.

Acknowledgements/funding

Acknowledgement should be made of those who do not meet the criteria for authorship but who have made contribution to the

design, data collection or manuscript preparation, as well as funding and material support.

Competing interests

All authors are to declare all potential, perceived, or real competing interests. If an author has no potential conflicts, please state.

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Authors are responsible for the accuracy of references. References should be numbered with superscript Arabic numerals in consecutive numerical order of appearance. Journal titles should be abbreviated according to the National Library of Medicine. References should be formatted according to the International Committee of Medical Journal Editors' (ICMJE) 'Uniform Requirements for Manuscripts Submitted to Biomedical Journals'.

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Original research papers should follow the 'IMRAD' structure: Introduction, Methods, Results, and Discussion. Relevant sub-headings may be used.

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These articles may cover any aspect of performance improvement in primary health care including health promotion, prevention and clinical interventions and programmes. These evaluations or audits should usually present evidence to indicate that a problem of quality of practice may exist, suggest indications for changes in practice, or contribute towards defining standards or developing measures of outcome. We wish to encourage submissions from practices, Primary Health Organisations (PHOs) and other organisations of audits and details of your programmes and other initiatives that you consider to be contributions to new knowledge. These include both activities that have been successful and those that have not. Sharing this learning allows us to learn from each other and avoid duplication. Such submissions will be peer-reviewed but under different criteria from full research articles.

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Maximum word count: 2000 words (excluding Title page, Abstract, Tables, Acknowledgements and contributions and the References)

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Editorials are commentaries and statements of informed opinion. They are usually commissioned by the Editor although unsolicited editorials are also considered. Authors considering submitting an editorial should discuss this with the editor (editor@rnzcgp.org.nz) prior to preparation. We also welcome suggestions for topics we could cover in our editorials.

Back to back

This section is designed to stimulate debate with two professionals presenting their opposing views regarding a clinical, ethical or political issue. In general these pieces are commissioned by the Editor but readers are welcome to suggest topics for debate.

Essays and opinion pieces

Essays include perspectives (present a specific point of view), discussions (explore a new idea) and reflections that explore areas of uncertainty, of ethics, of aspects of care for which there is no one right answer. These may include accounts of personal experience. Essays should be short and pithy with a clear and focussed message. Maximum count usually 1500 words.

Case reports

We will consider publishing reports of cases that raise interesting diagnostic or management issues, stimulate debate, address areas of uncertainty or controversy or present ethical concerns. Maximum word length is 800 words and photographs can be included. If your patients may be identifiable despite their names not being attached, then please have them sign a Patient Consent Form.

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Letters can be used to respond to published papers, briefly report original research or case reports, or raise matters of interest relevant to primary care health care. The best letters are succinct and stimulating, with a maximum of 400 words.

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We publish reviews of books written by NZ authors relating to primary health care topics. Authors of such books are invited to arrange for their publisher to forward a copy to the Editorial Office of the RNZCGP, Level 3, 88 The Terrace, PO Box 10-440, Wellington.