Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals reviewed in this issue

Am Fam Physician*
Am J Sports Med*
Aust N Z J Surg*
Br Homeopath J*
Br J Sports Med*
Can Fam Physician*
Intern Med J*
J Fam Pract*
JAMA*
Obstet Gynecol*
Postgrad Med*
Prim Care*
Sci Am*
*Journals indexed in Index Medicus

Alcohol and Substance Abuse

22-001 Validation of a single screening question for problem drinking.

Williams R, Vinson DC. J Fam Pract. April 2001. Vol.50. No.4. p.307-12.

Reviewed by Dr Bruce Adlam

Review: This study hoped to confirm the sensitivity and specificity of a single screening question for problem drinking: 'When was the last time you had more than X drinks in one day?', where X=4 for women and X=5 for men. This was a cross-sectional study of adult patients presenting to three emergency departments within 48 hours of an injury. The answers to the question were coded as never, more than 12 months ago, three to 12 months ago, and within the past three months. Considering 'within the last three months' as positive, the sensitivity of the single question was 86%, and the specificity was 86%. In men (n=1432), sensitivity and specificity were 88% and 81%; in women, 83% and 91%. Conclusion: A single question about the last episode of heavy drinking has clinically useful sensitivity and specificity in detecting hazardous drinking and alcohol use disorders (see 22-002 for the commentary).

Comment: This is the type of question that could easily be informally introduced into a patient consultation.

22-002 In search of the Holy Grail for the detection of hazardous drinking.

Fleming MF. J Fam Pract. April 2001. Vol.50. No.4. p.321-2.

Reviewed by Dr Bruce Adlam

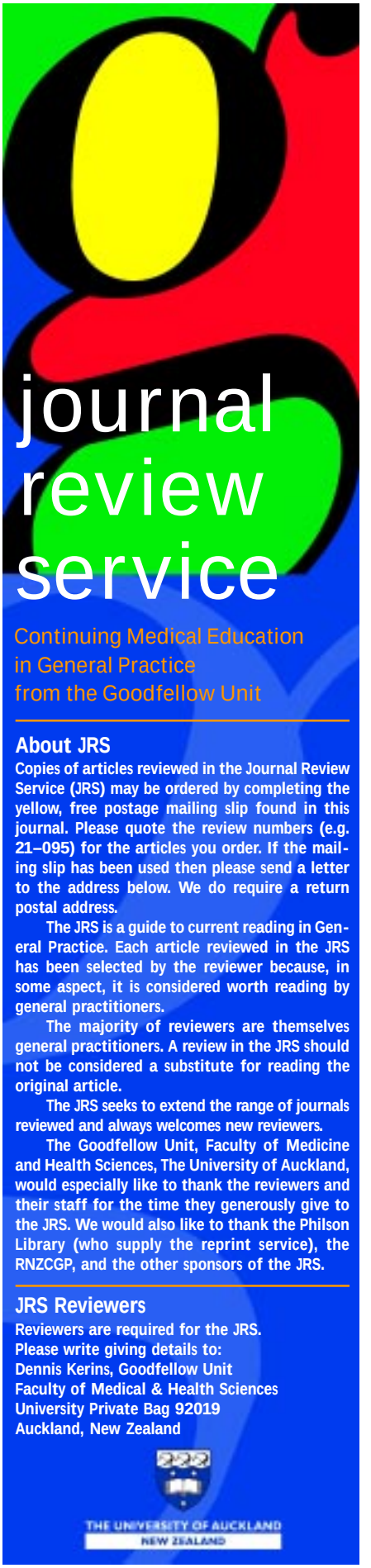
Review: See 22-001 and 22-003.

22-003 Three questions can detect hazardous drinkers.

Gordon AJ, Maisto SA, McNeil M, et al. J Fam Pract. April 2001. Vol.50. No.4. p.313-20.

Reviewed by Dr Bruce Adlam

Review: This study evaluated the Alcohol Use Disorders Identification Test (AUDIT) and identified a shorter version that could be used in the general practice setting. In a large primary care sample, a three-question version of the AUDIT identified hazardous drinkers as well as the full AUDIT when such drinkers were defined by quantity-frequency criterion. This version of the AUDIT may be useful as an initial screen for assessing hazardous drinking behaviour. However, although the CAGE is a valuable tool for identifying alcohol abuse and dependence, it is not as useful for identifying less serious behaviours, such as hazardous drinking. The first three questions of the audit are as effective as the full audit in identifying hazardous drinkers and the third question identifies the problem drinker and is the same single question as that in the article by Williams and Vinson (see 22-001). The article does not spell



these questions out so I have kindly done this for you (scores for each answer are in brackets). 1. How often do you have a drink containing alcohol? (0) Never, (1) Monthly or less, (2) two to four times a month, (3) two to three times a week, (4) four or more times a week; 2. How many standard drinks do you have on a typical day when you are drinking? (0) one or two, (1) three to four, (2) five or six, (3) seven to nine, (4) ten or more; 3. How often do you have six or more standard drinks on one occasion? (0) Never, (1) Less than monthly, (2) Monthly, (3) Weekly, (4) Daily or almost daily. (See 22-002 for the commentary.)

Comment: A score of three or greater indicate hazardous drinking. A score of two, three or four in Question 3 indicates problem drinking.

Cardiovascular System

22-004 Should calcium channel blockers be used as first-line antihypertensive therapy?

Reust CE. J Fam Pract. March 2001. Vol.50. No.3. p.258.

Reviewed by Dr Bruce Adlam

Review: You have probably seen this in other reviews but a reminder might not do any harm. The authors performed a meta-analysis of randomised controlled trials comparing CCBs with first-line antihypertensives regarding their effects on cardiovascular events. CCBs should not be used as first-line antihypertensive therapy in patients at risk for coronary heart disease and heart failure. Although CCBs lower blood pressure, their effect on preventing acute myocardial infarction, congestive heart failure, and overall cardiovascular mortality is less favorable than with other first-line therapies. (Original article reviewed: Lancet 2000; 356: 1949–54.)

Comment: This meta-analysis supports the recommendation of the Sixth Report on Prevention, Detection, Evaluation and Treatment of High Blood Pressure – use diuretics and ß-blockers as first-line agents.

22-005 Mysteries of mitral valve prolapse: proper treatment requires consideration of all clues.

Mulumudi MS, Vivekananthan K. Postgrad Med. August 2001. Vol.110. No.2. p.43-54.

Reviewed by Dr Chris Milne

Review: Mitral valve prolapse occurs in 2.4% of people, with a slight female predominance. Complications are rare, and tend to occur in those with a mitral systolic murmur, thickened leaflets or LV enlargement. Mitral regurgitation, infective endocarditis and stroke are recognised complications. Antibiotic prophylaxis should be given to those with a click and murmur, or a click with echo evidence of mitral regurgitation.

Comment: Useful update. It confirms my belief that this is usually a benign disorder, and is less prevalent than we once thought.

22-006 Current guidelines for the management of unstable angina: a new diagnostic and management paradigm.

Aroney C, Boyden AN, Jelinek MV, et al. Intern Med J. March 2001. Vol.31. No.2. p.104-11.

Reviewed by Dr Helen Moriarty

Review: The National Heart Foundation of Australia has developed new guidelines, in association with the Cardiac Society of Australia and New Zealand, for management of acute coronary syndrome. These reflect a move toward sensitive diagnostic strategies that stratify the risk of MI for the patient, and toward aggressive, invasive management of high risk patients.

Comment: Well worth reading. Cardiac troponins, ECG, changes as well as signs and symptoms, are used to stratify risk.

22-007 Individualised treatment of heart failure.

Troughton RW, Richards AM, Nicholls MG. Intern Med J. April 2001. Vol.31. No.3. p.138-41.

Reviewed by Dr Helen Moriarty

Review: This paper describes the concept of tailoring treatment to the individual, using as an example a study of 69 patients with symptomatic heart failure, ejection fraction <40%. Brain peptides – BNP and atrial natiuretic peptide ANP are powerful prognostic factors. Treatments which reduce the work load and stretch of the L ventricle cause BNP to fall. The probability of a cardiovascular event in six months is 50% lower when BNP levels are closely managed. ACE inhibitors potenuate BNP, so may require a different target level of BNP to be attained for optimal management.

22-008 Spironolactone in left-sided heart failure: how does it fit in?

Margo KL, Luttermoser G, Shaughnessy AF. Am Fam Physician. 15 October 2001. Vol.64. No.8. p.1393-9.

Reviewed by Dr Len Brake

Review: A potassium sparing diuretic and aldosterone blocking agent this drug was thought to be confined to

history. Now it has been shown to work synergistically with ACE inhibitors and decreases mortality from left sided congestive heart failure. This is an excellent update and is available as a pdf download from www.aafp.org.

Communicable Diseases, Infections and Parasites

22-009 What clinical features are useful in diagnosing strep throat?

Eaton CA. J Fam Pract. March 2001. Vol.50. No.3. p.201.

Reviewed by Dr Bruce Adlam

Review: Are you sick of reading about this? This is one of the better reviews that acknowledges that always performing a diagnostic laboratory test to uncover group A streptococcus is both impractical and costly. Identifying clinical correlates of strep throat would be useful. The presence of tonsillar exudate or pharyngeal exudates, and a history of streptococcus exposure in the previous two weeks were most useful in predicting current streptococcus pharyngitis (LR+ = 3.4, 2.1, and 1.9, respectively). The absence of tender anterior cervical lymph nodes, tonsillar enlargement, and tonsillar or pharyngeal exudate was most useful in ruling out strep throat (LR- = 0.60, 0.63, and 0.74, respectively). (Original article reviewed: JAMA 2000; 284: 2912-8.)

Comment: There you go.

22-010 Bioterrorism on the home front: a new challenge for American medicine.

Lane HC, Fauci AS. JAMA. 28 November 2001. Vol.286. No.20. p.2595-7.

Reviewed by Dr Len Brake

Review: The first cases of inhalation anthrax in the USA for about 30 years has JAMA devoting much wordage to this disease. This is an editorial and has summarised all relevant detail including history, treatment and has included the link to the CDC's website (See 22-011 and 22-012).

Comment: Very compulsive reading.

22-011 Clinical presentation of inhalational anthrax following bioterrorism exposure: report of two surviving patients.

Mayer TA, Bersoff-Matcha S, Murphy C, et al. JAMA. 28 November 2001. Vol.286. No.20. p.2549-53.

Reviewed by Dr Len Brake

Review: Clinical presentation, diagnostic workup and initial therapy of two postal workers with inhalation anthrax. The clinical course of both cases is itemised and so unfortunately are the autopsy results.

Comment: This is un-put-downable. It is striking how normal 'flu-like' the illness is for five to six days. (See 22-0010 and 22-012).

22-012 Death due to bioterrorism-related inhalational anthrax: report of 2 patients.

Borio L, Frank D, Mani V, et al. JAMA. 28 November 2001. Vol.286. No.20. p.2554-9.

Reviewed by Dr Len Brake

Review: See 22-010 and 22-011.

22-013 Battling biofilms.

Costerton JW, Stewart PS. Sci Am. July 2001. Vol.285. No.1. p.61-7.

Reviewed by Dr Ron Vautier

Review: Bacteria in nature very often live embedded in a gooey extracellular matrix, known as a biofilm. This often makes them difficult to eradicate with conventional antibiotics. Increasing knowledge of the formation and properties of biofilms, including the molecular signaling between individual bacteria, is here described.

Comment: This is useful background knowledge to understand what is going on with urethral catheters, prostate infections, kidney stones, some chronic otitis media, etc.

22-014 Changes in hepatitis C-related liver disease in a large clinic population.

Ostapowicz G, Dallinger M, Bell SJ, et al. Intern Med J. March 2001. Vol.31. No.2. p.90-6.

Reviewed by Dr Helen Moriarty

Review: A study that was hospital-based but came to the conclusion that most patients are diagnosed HCV positive in general practice. Early estimates of cirrhosis and HCC may have been over-estimates based on the specialised nature of HCV clinics where most research is based. This study also is possibly providing over-estimates of disease burden, for the same reason.

Comment: The ultimate disease burden of Hepatitis C is likely to be great in the future. Host factors, such as alcohol intake, may be important in determining progression to cirrhosis.

Dermatology

22-015 What is the best oral antifungal medication for tinea capitis?

Johnston KL, Chambliss ML. J Fam Pract. March 2001. Vol.50. No.3. p.206-7.

Reviewed by Dr Bruce Adlam

Review: Terbinafine is effective, safe for use in children, and relatively inexpensive, and it offers a shorter course of therapy than griseofulvin. Unfortunately, it is not available in liquid form. Fluconazole is available in liquid form and appears to be effective and safe, but fewer clinical trials have been published about it. Griseofulvin taken for six to eight weeks remains an effective therapy for tinea capitis. Ketoconazole and Itraconazole are not as safe and have variable efficacy. There are insufficient randomised controlled trials directly comparing these agents to clearly establish a superior medication. (Grade of Recommendation: B, small randomised controlled trials with limited head-to-head comparisons of drugs.)

Comment: This is an excellent short article.

22-016 The terminology of skin disorders.

Mayer ME. Prim Care. June 2000. Vol.27. No.2. p.277-87.

Reviewed by Dr M Hewitt

Review: Careful, clear and precise detailing of what one sees is, in it-

self, part of the diagnostic process. For skin disorders, terminology being correct is essential. This article makes it clear.

22-017 Pearls in the management of acne: an advanced approach.
Usatine RP, Quan MA. Prim Care. June 2000. Vol.27. No.2. p.289-308.
Reviewed by Dr M Hewitt
Review: The pathophysiology of acne is discussed, followed by descriptive classification and treatment review.
Comment: Excellent review and helpful.

22-018 Rosacea.
Zuber TJ. Prim Care. June 2000. Vol.27. No.2. p.309-18.
Reviewed by Dr M Hewitt
Review: A good account of the condition which is common in the older age group of the adult population. Ocular presentations are discussed along with up-to-date treatment.
Comment: Still can't fix the vascular reactivity associated with the condition.

22-019 Hair disorders.
Jackson EA. Prim Care. June 2000. Vol.27. No.2. p.319-32.
Reviewed by Dr M Hewitt
Review: The article reviews common hair disorders. Anatomy and life cycle of the hair is presented, with much of the article then looking at common population concerns; such as male pattern baldness and psychological disorders presenting with hair problems.
Comment: Don't ask your hairdresser. See your Doctor! Some good website references for downloading clinical photographs.

22-020 Nail disorders.
Mayeaux Jr, EJ. Prim Care. June 2000. Vol.27. No.2. p.333-51.
Reviewed by Dr M Hewitt
Review: Nail disorders accurately reflect certain disease states. Good history taking and sound knowledge will result in accurate diagnosis. Examination techniques and anatomical changes in the nail are discussed and reviewed.
Comment: Helpful illustrations for psoriasis and lichen planus.

22-021 Pediatric exanthems.
Gable EK, Liu G, Morrell DS. Prim Care. June 2000. Vol.27. No.2. p.353-69.
Reviewed by Dr M Hewitt
Review: It is common for a childhood illness, especially febrile, to present with a skin rash. The authors have described 12 common presentations and discuss a sensible way for a primary health care provider to evaluate them. Description, presentation and history are key elements in correct diagnosis.
Comment: Slapped cheek, fifth and sixth disease, Kawasaki syndrome, they're all there.

22-022 Psoriasis.
Drew GS. Prim Care. June 2000. Vol.27. No.2. p.385-406.
Reviewed by Dr M Hewitt
Review: Pathogenesis, diagnosis, management and treatment are discussed. Topicals are reviewed with nothing new mentioned, and the use of cyclosporine and methotrexate covered.
Comment: Anthralin in US-speak is dithranol.

22-023 Fungal skin disorders.
Rupke SJ. Prim Care. June 2000. Vol.27. No.2. p.407-21.
Reviewed by Dr M Hewitt
Review: Yeasts and moulds and how well they grow in our skin is discussed along with pictures to assist with accurate diagnosis and assess response to treatment. Some pharmacological background on polyenes and azoles is given in the context of treatment.

22-024 Cutaneous warts: diagnosis and treatment.
Plasencia JM. Prim Care. June 2000. Vol.27. No.2. p.423-34.
Reviewed by Dr M Hewitt
Review: All about HPV and how it affects the skin, manifesting in warts of various types and found in various locations. Cimetidine is something new to try for difficult children's warts. Tape occlusion for the nature brigade is also an effective remedy in children. For the difficult one, benign neglect works in 66% of cases in two years.

Ear, Nose and Throat

22-025 Management of the patient with Otitis Externa.
Holten KB, Gick J. J Fam Pract. April 2001. Vol.50. No.4. p.353-60.
Reviewed by Dr Bruce Adlam
Review: This is an excellent article on treatment of otitis externa, especially for the lucky beach-based GP. There is a lot of useful information in it including management of necrotising (malignant) otitis externa. For those who just need an update the following may be of interest:- The best evidence (grade of evidence: A) demonstrates equivalent results with ear cleaning, an ear wick, and any of the choices of topical agents - acidifying agents, antibiotics, antibiotic and steroid combinations, or antifungal agents. Physicians should treat patients with one of the following regimens for at least four days: (a) ear cleaning + ear wick + acidifying agent dosed four times daily, (b) ear cleaning + ear wick + topical antibiotic dosed four times daily (twice daily if quinolone), (c) ear cleaning + ear wick + topical antibiotic/steroid combination dosed four times daily (twice daily if quinolone).
Comment: The ear is best cleaned by simply irrigating the canal. Be sure to look for a foreign body, particularly in younger patients. For a wick, use either 5mm gauze, or the Pope ear wick (Merocel Corporation, Mystic, Conn). The wick helps draw topical medications into the affected canal, particularly when it is obstructed. The patient should return in approximately two days for removal of the wick and reassessment. Don't forget analgesics.

Endocrinology

22-026 Ramipril and the development of diabetes.

Yusuf S, Gerstein H, Hoogwerf B, et al. JAMA. 17 October 2001. Vol.286. No.15. p.1882-5.
Reviewed by Dr Len Brake
Review: Ramipril is an ACE inhibitor and this study compares it to placebo in preventing diabetes II. Consistently the use of ramipril almost halved the incidence of diabetes diagnoses. Exciting possibilities but 'needs further work' is the conclusion. Interesting to read the connection between ACE inhibitors, diabetes II and the prevention thereof.

22-027 Cutaneous manifestations of diabetes mellitus.

Paron NG, Lambert PW. Prim Care. June 2000. Vol.27. No.2. p.371-83.
Reviewed by Dr M Hewitt
Review: There is a rising prevalence of diabetes mellitus in the developed world due to obesity and lifestyle changes in activity and diet. The article looks at skin conditions which have a strong association with diabetes to assist in early diagnosis. With established diagnosis, the authors mention manifestations related to infectious origins, complications of the disease or the treatment.

Eye Diseases

22-028 Hormone replacement therapy and dry eye syndrome.

Schaumberg DA, Buring JE, Sullivan DA, et al. JAMA. 7 November 2001. Vol.286. No.17. p.2114-9.
Reviewed by Dr Len Brake
Review: An impression is that the use of HRT has peaked out in this country but it is still a popular treatment for menopausal symptoms. Earlier research had indicated that oestrogen may have detrimental effects on the tear film - 'dry eye syndrome' - this is assessed in this large cohort study. Indeed the correlation between HRT and the dry eye syndrome is confirmed.
Comment: Those prescribing HRT should warn women of the problem. It's no good saying 'read this and weep' because most of them can't. Weep that is.

22-029 The challenge of macular degeneration.

Sun H, Nathans J. Sci Am. October 2001. Vol.285. No.4. p.60-7.
Reviewed by Dr Ron Vautier
Review: The condition arises from malfunctioning of cells of the retinal pigment epithelium which normally deal with degenerating outer segments of the rods and cones. Genetic studies of closely related disorders are starting to elucidate the mechanisms involved in age related maculopathy. Current and potential future treatments are described.
Comment: Quite fascinating.

Family Practice

22-030 Continuity of care and trust in one's physician: A comparison of the United States and the United Kingdom.

Mainous AG III, Baker R, Love MM, et al. J Fam Pract. March 2001. Vol.50. No.3. p.246.
Reviewed by Dr Bruce Adlam
Review: This is not the type of article that GPs in New Zealand would request as they feel it in their water anyway. So I will include the results here as it is endorsing of the principles of general practice we hold dear. The objective was to explore the relationship between continuity of care and trust in one's physician, particularly in terms of the differences between the United States and the United Kingdom. Although UK patients (98.1%) were more likely than US patients (88.2%) to report having a usual site of care (P=.0001), there was no difference between the UK patients (81.6%) and the US patients (79.0%) in likelihood of having a regular physician (P=.36). A total of 53.0% of the UK patients and 8.0% of the US patients have had their regular physicians for more than six years (P=.0001). US patients (83.9%) are more likely than UK patients (60.4%) to value continuity with a physician (P=.0001). The US patients (mean=44.9) have a slightly higher level of trust in their physicians than the UK patients (mean=43.8; P=.02), although both groups have high levels of trust. In a multivariate model, country of residence had no independent relationship with trust, but continuity of care was significantly related. (See 22-031 for the commentary.)
Comment: If you have skipped the gobbledy-gook it means that higher continuity of care is associated with a higher level of trust between a patient and a physician. The final comment was that 'Efforts to improve the relationship between patients and physicians may improve the quality and outcomes of care'. Our issue in New Zealand would be the political environment to 'preserve' the relationship while not denying that improvement is always desirable.

22-031 The North American Primary Care Research Group: Supporting research by and for family physicians.

Westfall JM, Ebell M, MaCaulay AC. J Fam Pract. March 2001. Vol.50. No.3. p.245.
Reviewed by Dr Bruce Adlam
Review: See 22-030.

Gastroenterology

22-032 Why barium enemas fail to identify colorectal cancers.

McDonald S, Lyall P, Israel L, et al. Aust N Z J Surg. November 2001. Vol.71. No.11. p.631-3.
Reviewed by Dr Len Brake
Review: A retrospective review of 313 patients with proven bowel cancer who had had a barium enema within two years of diagnosis; 6.7% of the cancers were missed. The whys and wherefores are looked at with advantages of the BE over colonscopy and vice versa (See 22-033).
Comment: A New Zealand paper; highly relevant.

22-033 Barium enema: to be or not to be: is that the question?
Mendelson RM. Aust N Z J Surg. November 2001. Vol.71. No.11. p.627-8.
Reviewed by Dr Len Brake
Review: See 22-032.

22-034 NSAID-related gastrointestinal injury: evidence-based approach to a preventable complication.
Fennerty MB. Postgrad Med. September 2001. Vol.110. No.3. p.87-94.
Reviewed by Dr Chris Milne
Review: The optimal method of preventing NSAID related gastrointestinal injury is to avoid the use of these agents. Even doses of aspirin as low as 75mg daily can double the risk of ulcer bleeding. Co-prescription of proton pump inhibitors with NSAIDs is one useful strategy, the other is to use a selective COX-2 inhibitor.
Comment: Useful summary article with the evidence base for what we should do in routine clinical practice.

Genetics

22-035 Complete genomic screen in Parkinson disease: evidence for multiple genes.
Scott WK, Nance MA, Watts RL, et al. JAMA. 14 November 2001. Vol.286. No.18. p.2239-44.
Reviewed by Dr Len Brake
Review: The number of patients affected with Parkinson Disease (PD) is increasing as the population ages. The relative contribution of genes vs environment in causes of PD has been controversial. Twin studies have suggested little genetic contribution. The data presented in this paper suggests that the parkin gene is important in early onset PD and that multiple genetic factors are important in later-onset PD (see 22-036 and 22-037).

22-036 Association of single-nucleotide polymorphisms of the Tau Gene with late-onset Parkinson disease.
Martin ER, Scott WK, Nance MA, et al. JAMA. 14 November 2001. Vol.286. No.18. p.2245-50.
Reviewed by Dr Len Brake
Review: See 22-035 and 22-037.

22-037 Tau and Parkinson disease.
Spillantini MG, Goedert M. JAMA. 14 November 2001. Vol.286. No.18. p.2324-6.
Reviewed by Dr Len Brake
Review: See 22-035 and 22-036.

22-038 Population screening for HFE-associated haemochromatosis: should we have to pay for our genes?
Yapp TR, Eijkelkamp EJ, Powell LW. Intern Med J. January/February 2001. Vol.31. No.1. p.48-52.
Reviewed by Dr Helen Moriarty
Review: Interest in haemochromatosis has taken a revival since the discovery of the HFE gene and its mutations, on chromosome 6. Mis-sense mutations are quite common, can be used to diagnose cases and to screen for patients with a predisposition to iron overload. However, 30% of homozygotes will not express iron overload in their lifetime. Despite this, haemochromatosis meets the WHO criteria for screening.
Comment: This paper debates phenotype (transferrin) vs genotype (DNA test) screening for the disease. Tests of phenotype over age 15 years show which of those with the genotype are going to develop expression of haemochromatosis.

Geriatrics

22-039 Urinary symptoms and incontinence in an urban community: prevalence and associated factors in older men and women.
Muscatello DJ, Rissel C, Szonyi G. Intern Med J. April 2001. Vol.31. No.2. p.151-60.
Reviewed by Dr Helen Moriarty
Review: A household survey in New South Wales of people aged over 41 years revealed that urinary symptoms are very common, and more than half of patients do not seek treatment. Associated factors include obesity, low SE status, fair or poor self-rated health status, age >70 years.
Comment: A broader focus should be taken on urinary symptoms. Those who seek treatment may be a specific subset of the patients who have this problem in the community. Symptoms should be clearly delineated in order to recognise the various syndromes that cause this symptom.

22-040 Early diagnosis of dementia.
Santacruz KS, Swagerty D. Am Fam Physician. 15 February 2001. Vol.63. No.4. p.703-13.
Reviewed by Dr J R Elliott
Review: An article setting out the early signs and symptoms of dementia. A comparison with age-related cognitive decline and investigation to exclude other diagnoses including delirium and other potentially treatable aetiologies. A summary of the different types of dementia, including Alzheimer's, multi-infarct, and dementia with Lewy Bodies. Patient information page attached. See editoral 22-041.
Comment: A simply excellent, top drawer, reference article when faced with any patient in whom the diagnosis of dementia is to be considered. Clear, concise and mandatory reading. Clinically extremely relevant.

22-041 Mild cognitive impairment in the elderly.
Brandt J. Am Fam Physician. 15 February 2001. Vol.63. No.4. p.620-6.
Reviewed by Dr J R Elliott
Review: See 22-040.

Gynecology

22-042 Chronic vulvovaginal candidiasis.
Nyirjesy P. Am Fam Physician. 15 February 2001. Vol.63. No.4. p.697-702.
Reviewed by Dr Sarah Turner
Review: This article summarises current concepts in the evaluation of women with chronic vulvovaginal symptoms. It looks in more detail at recurrent vulvovaginal candidiasis

and its possible causes and treatment strategies.
Comment: This is a topic which we tend to ignore as it can be a source of frustration for both the patient and doctor. This article is very helpful.

22-043 Endometrial biopsy.

Zuber TJ. Am Fam Physician. 15 March 2001. Vol.63. No.6. p.1131-5.
Reviewed by Dr William Ferguson
Review: A detailed description of method, materials, indications, contraindications, complications and interpretation of this relatively simple office procedure. Patient information page attached. Also Official Procedures form attached.
Comment: With a small amount of training this should become part of a new wave of skills in General Practice that GPs with a solid background in gynaecology can usefully add to their repertoire.

Health Services

22-044 Evaluating health-care delivery: Hospital in the home.

Ruth D, Greenberg PB, Campbell DA. Intern Med J. April 2001. Vol.31. No.3. p.135-7.
Reviewed by Dr Helen Moriarty
Review: An overview of the hospital-in-the-home programme in Australia. There are many different programmes under as many different funding arrangements. Some programmes have been found to cost more than in-hospital care, some to cost less.
Comment: The editorial cautions against hasty analysis and decisions based upon poor data. HITH has to be tailored to the expectations and wishes of the patients. This calls for a different skill set in the primary care workforce.

Homeopathy

22-045 Homeopathic pathogenetic trials of Acidum malicum and Acidum ascorbicum.

Fisher P, Dantas F. Br Homeopath J. July 2001. Vol.90. No.3. p.118-25.
Reviewed by Dr Mimi Irwin
Review: This is a study that investigated the traditional homeopathic activity of provings. Two substances Acidum malicum and Acidum ascorbicum diluted to 12cH were taken by healthy volunteers. Both studies were double blind, placebo controlled and randomised. There was no difference between verrum and placebo groups when the study was analysed.
Comment: The study groups were small - a problem that dogs homeopathic research. This study opens a window on to how healthy individuals can produce a myriad of symptoms especially if asked to record them!

22-046 Effects of homeopathic treatment in women with premenstrual syndrome: a pilot study.

Yakir M, Kreitler S, Brzezinski A, et al. Br Homeopath J. July 2001. Vol.90. No.3. p.148-53.
Reviewed by Dr Mimi Irwin
Review: The homeopathic treatment of premenstrual syndrome was evaluated in this study. It is a randomised, controlled double blind clinical trial with two months baseline assessment and post treatment follow-up for three months. Five different medications were used and matched to the patients symptomatology. Patients receiving active medication had less time off work, reduced their intake of orthodox medication and reported less somatic and psychological symptoms. The treatment was one dose only.
Comment: This is an excellent study hampered by small numbers. This article should be most useful to anyone starting out in homeopathy.

22-047 Patient benefit survey: Liverpool Regional Department of Homoeopathic Medicine.

Richardson WR. Br Homeopath J. July 2001. Vol.90. No.3. p.158-62.
Reviewed by Dr Mimi Irwin
Review: This outcome survey was carried out over 12 months at the Liverpool Regional Department of Homeopathic Medicine. There were 1 100 patients surveyed with the Glasgow Homeopathic Hospital Outcome Score. This is a self assessment tool. 76.6% of patients reported an improvement and 52% reduced their conventional medication.
Comment: A number of outcome studies have been done in recent years. They show high patient satisfaction, a similar degree of improvement and reduction in use of pharmaceutical agents. Homeopathy appears helpful for PMS, recurrent URTIs, eczema, headache and menopausal symptoms. Its not particularly useful in psoriasis.

Immunology and Allergy

22-048 Do patients with local reactions to allergy shots require dosage reductions for subsequent injections?

Kinkade S. J Fam Pract. March 2001. Vol.50. No.3. p.202.
Reviewed by Dr Bruce Adlam
Review: Many physicians reduce the dose of allergen immunotherapy when patients have significant local reactions to their allergy shots, believing that these patients are at higher risk for systemic reactions. This dose reduction is made despite the fact that the World Health Organization stated in a position paper on allergen immunotherapy that local reactions are not predictive of subsequent systemic reactions. This big study of nearly 13 000 allergy shots supports recommendations that an allergy shot dosage reduction is not needed after a local reaction to the previous dose, unless the reaction is larger than 8 cm. There were no significant differences in the rate of systemic reactions between those who had their dose reduced because of a local reaction and those who did not. (Original article reviewed: J Allergy Clin Immunol 2000; 106: 840-3.)

Musculoskeletal System

22-049 Outcome of surgery for chronic achilles tendinopathy: A critical review.

Tallon C, Coleman BD, Khan KM, et al. Am J Sports Med. May/June 2001. Vol.29. No.3. p.315-20.
Reviewed by Dr C Hanna

Review: This paper critically assessed 26 studies reporting surgical outcomes in patients with chronic achilles tendinopathy
Comment: They concluded that those papers that were better designed generally reported a poorer outcome, and they provide guidelines for planning future studies.

22-050 Early rheumatoid arthritis: can we predict its outcome.

Williamson AA, McColl GJ. Intern Med J. April 2001. Vol.31. No.2. p.168-80.
Reviewed by Dr Helen Moriarty
Review: This review paper looks firstly at the difficulties in evaluating issues of rheumatoid arthritis due to imprecise diagnosis in the early stages, changing treatment models, differing outcome measures, new tests, and interpretation of genetic markers. It then suggests an approach to initial management of RA.
Comment: The issues are not only confounded by the rapid development of tests and treatment agents, but also the lack of understanding of prognostic factors in RA.

Neurology

22-051 Are angiotensin-converting enzyme (ACE) inhibitors effective in preventing migraine in nonhypertensive patients?

Montgomery L. J Fam Pract. April 2001. Vol.50. No.4. p.299.
Reviewed by Dr Bruce Adlam
Review: This well-designed study of lisinopril for moderate migraine sufferers suggests that another class of medications may be beneficial for prophylaxis. Though a relatively modest decrease in headaches was reported, and there was wide variability in the results, lisinopril was well tolerated and has advantages over current prophylactic medications. A certain subset of patients responded very well to treatment. For patients with frequent migraines who have not responded to other prophylactic medications, a trial of ACE inhibitors may be useful. The dose of lisinopril was 10 mg for one week, then 20 mg for the remaining 11 weeks. (Original article reviewed in: BMJ 2001; 322: 19-22).
Comment: Note this is a small study and results may not be generalisable.

Obstetrics

22-052 What medications are safe and effective for heartburn during pregnancy?

Koenig CJ. J Fam Pract. April 2001. Vol.50. No.4. p.304-5.
Reviewed by Dr Bruce Adlam
Review: Ranitidine (150mg bd) is the best-studied agent effective for treatment of heartburn in pregnancy and even this study was limited by its short duration (<1 month) and small sample size (N=30). Some antacids are effective, but it may be prudent to avoid them in the first trimester until better safety studies are published. Although sucralfate, metoclopromide, and the proton pump inhibitors are probably safe in pregnancy, there is no data about their efficacy. (Grade of Recommendation: B.) In the antacid group, aluminum phosphate (cannot find a product listed in NZ) was the most effective. Patients who received a combination of magnesium and aluminum hydroxide for seven days had no more relief of symptoms than the placebo group. Atlay and colleagues found that sodium bicarbonate significantly reduced reflux symptoms compared with placebo (P=.021; NNT=6.0). Sorry no information specifically regarding alginates (i.e. Gaviscon, Mylanta) in heartburn relief.
Comment: Some issues are raised here about the safety of antacids during pregnancy. This could well be due to recall bias or other systematic biases inherent in case-control methodology.

22-053 Membrane sweeping in conjunction with labor induction.

Foong LC, Vanaja K, Tan G, et al. Obstet Gynecol. October 2000. Vol.96. No.4. p.539-42.
Reviewed by Dr William Ferguson
Review: This randomised trial looked for benefits in stripping or sweeping the membranes off the lower segment in conjunction with routine vaginal prostaglandins, to induce labour. There were clear benefits to labour and delivery in nulliparas with unfavourable cervices.
Comment: Shorter induction to labour intervals, lower doses of oxytocin and higher delivery rates all suggest this is a useful trick for facilitating inductions, especially when they are likely to be difficult.

22-054 A second-stage partogram.

Sizer AR, Evans J, Bailey SM, et al. Obstet Gynecol. November 2000. Vol.96. No.5. p.678-83.
Reviewed by Dr William Ferguson
Review: The value of a partogram in first stage was established 20 years ago, but what about a simplified partogram of the second stage of labour, based upon a scoring system of position and station? The sum of descent and position scores were plotted against time elapsed for 1 400 labouring women. The relative importance of position, station and total score were assessed for ability to predict mode of delivery by using logistic regression.
Comment: A fascinating dissection of the anatomy of the second stage, with some interesting but predictable associations. Worth reading to remind us of the need for close observation of progress in second stage.

Orthopedics

22-055 Anterior cruciate ligament function after tibial eminence fracture in skeletally mature patients.

Ahmad CS, Shubin Stein BE, Jeshuran W, et al. Am J Sports Med. May/June 2001. Vol.29. No.3. p.339-45.
Reviewed by Dr C Hanna
Review: Three groups of patients were assessed for functional knee score, joint laxity, and proprioception - ACL deficient patients, those who had had a bone-patellar tendon-bone graft reconstruction, and those who had had a tibial eminence avulsion fracture after reaching skeletal maturity.

Comment: This study shows that regardless of treatment there is a strong correlation between ACL laxity and loss of proprioception, and that there was no statistical difference between the ACL reconstruction group and the tibial eminence fracture group.

Paediatrics

22-056 Is teething in infants associated with fever or other symptoms?

Frank J, Drezner J. J Fam Pract. March 2001. Vol.50. No.3. p.257.
Reviewed by Dr Bruce Adlam

Review: Parents and clinicians have traditionally attributed to teething many symptoms, such as fever, pain, irritability, diarrhea, drooling, and sleep disturbance. However, little evidence exists to support this claim. The authors investigated the relationship between tooth eruption, fever, and teething symptoms. (Original article reviewed in: Pediatrics 2000; 106: 1374-9).

Comment: This study provided no conclusive evidence that a relationship exists between the eruption of teeth and the experience of symptoms. Temperature greater than 38°C or other serious symptoms in an infant should not be regarded by clinicians as due to teething and should be evaluated appropriately.

22-057 Is oral dexamethasone as effective as intramuscular dexamethasone for outpatient management of moderate croup?

Newton W. J Fam Pract. March 2001. Vol.50. No.3. p.260.
Reviewed by Dr Bruce Adlam

Review: Recent meta-analyses have concluded that steroids ameliorate croup, but questions remain about the effectiveness of oral dosing. This study provides evidence that a single dose of dexamethasone (0.6 mg/kg, maximum dose 8 mg) given orally is as effective as injectable administration for the outpatient treatment of moderate croup. Oral dexamethasone given in a syrup or jelly is well tolerated. Clinicians should feel comfortable using either oral or IM dexamethasone to treat patients with moderate croup. (Original article reviewed: Pediatrics 2000; 106: 1344-8.)

22-058 Children's UTIs in the new millennium.

White CT, Matsell DG. Can Fam Physician Med Fam Can. August 2001. Vol.47. p.1603-8.
Reviewed by Dr Mike Lyons

Review: Supports stated rationale for diagnosis, testing and treating UTI in children with evidence-based information (accepting limitations). Tables ten rules for take home messages that neatly summarise the article.

Comment: Practical reinforcement.

Pharmacology

22-059 Beyond chicken soup.

Haseltine WA. Sci Am. November 2001. Vol.285. No.5. p.44-51.
Reviewed by Dr Ron Vautier

Review: The number of anti-viral vaccines and drugs is increasing rapidly as scientists elucidate the details of virus life cycles and sequence their genomes. Thus new drugs are developed from a rational targeted approach rather than the previous one of try it and see.

Comment: This article offers an excellent review of current knowledge of viral structure and function, and is readily comprehensible.

Physician-Patient Relations

22-060 The factors associated with disclosure of intimate partner abuse to clinicians.

Rodriguez MA, Sheldon WR, Bauer HM, et al. J Fam Pract. April 2001. Vol.50. No.4. p.338-44.
Reviewed by Dr Bruce Adlam

Review: The goal of this study was to identify the prevalence, determinants of, and barriers to clinician-patient communication about intimate partner abuse. The study was conducted by telephone interviews with a random sample of 375 ethnically diverse abused women. Forty-two per cent (159) of the patients reported having communicated with a clinician about abuse. Significant independent predictors of communication were direct clinician questioning about abuse. Factors associated with lack of communication about abuse included immigrant status, and patient concerns about confidentiality. Barriers significantly associated with lack of communication were patients' perceptions that clinicians did not ask directly about abuse, beliefs that clinicians lack time and interest in discussing abuse, fears about involving police and courts, and concerns about confidentiality. Less than 15% of women patients in primary care settings report being asked about abuse by health care professionals. Yet the majority of women patients report that they favour direct questioning by clinicians about IPA and would reveal abuse histories if asked directly.

Comment: The hanging question is why health professionals don't ask the direct question? Is this a fear of the time that might be involved if it yields a positive answer, a sense that they lack the skills to deal with the answer, or that questioning about abuse is some mysterious skill that requires more than the empathy held by the majority of health professionals.

22-061 Why complaining is good for medicine.

Walton M. Intern Med J. March 2001. Vol.31. No.2. p.75-6.
Reviewed by Dr Helen Moriarty

Review: A short discussion paper that exhorts us all to look at the positive aspects of patient complaint - the encouragement of self assessment, maintenance of trust and of standards, leading to improvement in practices and protection of the public as well as reminding us of our ethical and professional obligations.

Preventive Medicine and Screening

22-062 Process evaluation of a tailored multifaceted approach to improving preventive care.

Baskerville NB, Hogg W, Lemelin J. J Fam Pract. March 2001. Vol.50. No.3. p.241.
Reviewed by Dr Bruce Adlam

Review: This original research, although small, looked at outreach facilitation to improve preventive performance in practices. This was set in Ontario. The main components for creating change are audit and feedback of preventive performance, achieving consensus on a plan for improvement, and implementing a reminder system. Ninety-five per cent of the physicians were either satisfied or very satisfied with the intervention, and 90% would have been willing to have the prevention facilitator continue working with their practice.

Comment: This RCT was confined to the implementation of the programmes and had no outcomes data of the efficacy of the programme, which is probably a big ask after only 17 months. There was no patient satisfaction data.

22-063 Screening for cancer: evaluating the evidence.

Gates TJ. Am Fam Physician. 1 February 2001. Vol.63. No.3. p.513-22.
Reviewed by Dr William Ferguson

Review: This paper arms the reader with the analytical skills necessary to consider the effectiveness and appropriateness of a screening programme. Some current areas of controversy are then discussed as examples.

Comment: Essential background knowledge for anyone implementing any screening programme, and a useful partner to the March 2001 paper on screening guidelines (see 22-064) and the editoral in this issue 22077.

22-064 The science and politics of cancer screening.

Dickey LL. Am Fam Physician. 1 February 2001. Vol.63. No.3. p.440, 442.
Reviewed by Dr William Ferguson

Review: See 22-063.

22-065 Cancer screening guidelines.

Zoorob R, Anderson R, Cefalu C, et al. Am Fam Physician. 15 March 2001. Vol.63. No.6. p.1101-12.
Reviewed by Dr William Ferguson

Review: This paper summarises the recommendations of a range of august American medical organisations on cancer screening. Included are recommendations on breast, cervical, colorectal, prostate, skin, testicular, endometrial, lung, oral and ovarian cancers. (See 22076).

Comment: A useful overview that could be used as a handy reference. The range of opinions is wide and it is useful to put NZ strategies in an international context of medical opinion.

Primary Health Care

22-066 Utilization of physicians' services under universal health insurance in Ontario.

Finkelstein M. J Fam Pract. March 2001. Vol.50. No.3. p.248.
Reviewed by Dr Bruce Adlam

Review: The objective of this study was to use population-based individual-level health and income information linked to health insurance utilisation data to determine whether the objective of access to care on the basis of need rather than income has been achieved in Ontario, Canada. The National Population Health Survey collected information about the health status and income of Canadians. Respondents to the 1995 survey were asked for approval to link their information to health insurance plan administrative databases. The respondents (N=2170) were aged 40 to 79 years and were residing in the province of Ontario. The outcome measures were per capita costs of care in relation to income and self-reported health status, and the odds of referral to a specialist in relation to income and health. Results showed lower-income households incurred higher per capita expenditures on physicians' services than higher-income households. Expenditures were significantly related to health status. After adjustment for health status, there was no association between income and the costs of total physician services, out of hospital services, or specialist care. The goal of those who developed Canada's universal health insurance system has been realised. Use of physicians' services is on the basis of need rather than income.

Comment: I've only included this as it raises questions regarding the different outcomes for the free under 6's scheme for children, and the issues regarding the hard to get to groups in New Zealand. (Published in the JFP as an abstract only.)

Procedures and Techniques

22-067 Fingertip injuries.

Wang QC, Johnson BA. Am Fam Physician. 15 May 2001. Vol.63. No.10. p.1961-66.
Reviewed by Dr William Ferguson

Review: A detailed review of the diagnosis and treatment of fingertip injuries, with useful recommendations on what needs referral.

Comment: A common presentation in general practice, yet one that can cause preventable permanent disability if mistakes are made.

Psychiatry and Psychology

22-068 Is imipramine or buspirone treatment effective in patients wishing to discontinue long-term benzodiazepine use?

Sontheimer DL, Ables AZ. J Fam Pract. March 2001. Vol.50. No.3. p.203.
Reviewed by Dr Bruce Adlam

Review: Discontinuation of benzodiazepines in patients on long-term treatment may be associated with restlessness, agitation, increased anxiety, insomnia, irritability, palpitations, and many other troublesome symptoms. This small study indicates that imipramine (25mg daily) is a viable adjunctive agent in promoting benzodiazepine discontinuation in

motivated patients who are dissatisfied with their treatment (82.5% free at three months cf 37.5% placebo NNT 2). However, the severity of withdrawal symptoms was worse in the imipramine-treated patients than with the buspirone- and placebo-treated patients. Buspirone (5mg daily) did not affect withdrawal rates, although the study probably did not have sufficient power to detect a benefit if one truly exists. (Original article reviewed: Am J Psychiatry 2000; 157: 1973-9.)

22-069 The truth and the hype of hypnosis.

Nash MR. Sci Am. July 2001. Vol.285. No.1. p.37-43.
Reviewed by Dr Ron Vautier

Review: Behavioural and physiological responses, including PET brain scanning, to hypnotic suggestion have been more rigorously determined in recent decades. Hypnosis can often help in treating pain, obesity, insomnia, anxiety and hypertension, and possibly in some asthma, skin conditions (including warts), and irritable bowel syndrome.
Comment: It would seem medical practitioners are significantly underutilising a useful and very safe therapeutic modality.

22-070 Preventing lithium intoxication: guide for physicians.

Delva NJ, Hawken ER. Can Fam Physician Med Fam Can. August 2001. Vol.47. p.1595-600.
Reviewed by Dr Mike Lyons

Review: This article raises the awareness of lithium toxicity. A case study highlights risk factors. Comorbidity, other medications and general patient assessment are stressed. The fallacy of relying solely on lithium levels is emphasised. Symptoms of toxicity and guidelines for monitoring are tabled.
Comment: A good reference article to consult when dealing with patients on lithium.

22-071 Depression in children and adolescents.

Son SE, Kirchner JT. Am Fam Physician. 15 November 2000. Vol.62. No.10. p.2297-308.
Reviewed by Dr Sarah Turner

Review: Reviews depression in children and adolescents in depth. Some valuable tools for diagnosing depression are given. Treatment with psychotherapy, tricyclic antidepressants and SSRIs is reviewed. Patient information page attached.
Comment: Very interesting. It is one of those things that can be very difficult to diagnose. I'm sure you will find a use for the diagnostic tools.

Research Design and Methodology

22-072 Hypothesis: The research page: Part 3: Power, sample size, and clinical significance.

Godwin M. Can Fam Physician Med Fam Can. July 2001. Vol.47. p.1441-3.
Reviewed by Dr Mike Lyons

Review: Part three in this series of succinct articles dealing with evidence. Explains alpha and beta errors, clinical and statistical significance, power and sample size by example and bell curve graphs.
Comment: Read this article if you want to answer the question: 'If I want to be 95% certain that any difference I see is not due to chance and 80% certain that if I conclude there is no difference I am correct, how many people do I need in this study?'

22-073 Evidence-based medicine: Science and art.

Godwin M, Dawes M. Can Fam Physician Med Fam Can. August 2001. Vol.47. p.1527-30.
Reviewed by Dr Mike Lyons

Review: This editorial integrates the current art and science of evidence-based medicine and explains the urgent need for a Global Medical Knowledge Database (GMKD) as recently proposed in the BMJ.
Comment: Eminently sensible - may even convince some sceptics. Fifteen essential references to current EBM sources.

Sports and Sports Medicine

22-074 Athletic activity after joint replacement.

Healy WL, Iorio R, Lemos MJ. Am J Sports Med. May/June 2001. Vol.29. No.3. p.377-88.
Reviewed by Dr C Hanna

Review: The first decade of the 21st century has been declared the 'Bone and Joint Decade' by 35 countries and 44 states in the United States. With an ageing population, the prevalence of arthritic joints is increasing. Remaining active has many health benefits.
Comment: This 'current concepts' article presents a consensus recommendation for appropriate exercise activity in patients who have had a joint replacement.

22-075 The use of local anaesthetic injections in professional football.

Orchard J. Br J Sports Med. 1 August 2001. Vol.35. No.4. p.212-3.
Reviewed by Dr Chris Milne

Review: Local anaesthetic injections are widely used in several professional football codes throughout the world. However, their use is banned by the International Rugby Board. John Orchard argues that in the professional game, an injection that increases the number of games where a player can take the field is justified. He makes a plea for published guidelines for rational use of local anaesthetic injections.
Comment: Very thought-provoking article. I would agree with most of his assertions, but feel that any published guidelines would have to be relatively general or they would be reinterpreted as rules by non-medical professionals (e.g. lawyers!).

22-076 Computerised cognitive assessment of athletes with sports related head injury.

Collie A, Darby D, Maruff P. Br J Sports Med. 1 October 2001. Vol.35. No.5. p.297-302.
Reviewed by Dr Chris Milne

Review: Traditional neuropsychological assessment of concussed players has been via paper based systems. Computerised cognitive tests have the capacity to detect very mild cognitive dysfunction, and demonstrate less 'practice effects' making them

more suitable for repeated use. They have yet to be fully validated, but probably represent the future of post concussion testing.
Comment: A useful idea. Implementation is probably a few seasons away, but these tests look promising.

22-077 Provocation by eucapnic voluntary hyperpnoea to identify exercise induced bronchoconstriction.

Anderson SD, Argyros GJ, Magnussen H, et al. Br J Sports Med. 1 October 2001. Vol.35. No.5. p.344-7.
Reviewed by Dr Chris Milne
Review: Sports administration, particularly the IOC Medical Commission, have been looking for a laboratory test that provides objective evidence of exercise induced asthma. This test looks like it fits the bill. It requires the subject to hyperventilate at 85% maximal voluntary ventilation, breathing dry air containing 5% carbon dioxide for 6 minutes. A fall of FEV1 of 10% or more from baseline is regarded as a positive test for exercise induced asthma/bronchospasm.
Comment: This is the future for international level asthmatic athletes. No longer will a doctor's letter be sufficient. These tests will need to be done before dispensation will be given to use ß2 agonists at an Olympic Games.

Surgery

22-078 Women's health after plastic surgery.

Englert H, Joyner E, McGill N, et al. Intern Med J. March 2001. Vol.31. No.2. p.77-89.
Reviewed by Dr Helen Moriarty
Review: A retrospective review of a cohort of Sydney women who had breast augmentation between 1979-1983. No association was found between this procedure and connective tissue disease, although axillary adenopathy and low titre ANA tests were detected more frequently in those who had silicone vs non-silicone plastic surgery.
Comment: The paper concludes that low titre ANA tests are of dubious significance for women who have had breast implants, there being no other differences detected for silicone-exposed women.

Therapeutics

22-079 Is rofecoxib safer than naproxen?

Adelman A. J Fam Pract. March 2001. Vol.50. No.3. p.204.
Reviewed by Dr Bruce Adlam
Review: The risk of gastrointestinal events is lower with rofecoxib (Vioxx) than with naproxen in patients treated continuously for one year with standard doses. The absolute difference between these two agents is small and should be weighed against the increased cost of rofecoxib. A recent study comparing celecoxib (Celebrex) with ibuprofen and diclofenac showed similar results. (Original article reviewed: N Engl J Med 2000; 343: 1520-28.)

22-080 How soon should serum potassium levels be monitored for patients started on diuretics?

Blanning A, Westfall JM. J Fam Pract. March 2001. Vol.50. No.3. p.207-8.
Reviewed by Dr Bruce Adlam
Review: Case series show that hypokalemia following initiation of diuretic therapy occurs in (7-56%) of patients usually within two to eight weeks. Patients taking diuretics should have a potassium level check in the first two to eight weeks after initiating therapy. Mild hypokalemia (3.1 to 3.4 mmol/L) may be transient, so a repeat measurement may be considered before initiating potassium replacement. This is another good review which suggests polypharmacy, glucocorticoids, and being female as risk factors. Dietary sodium restriction may also help to conserve potassium, because this will decrease urinary flow rate and potassium loss. The frequency with which to check potassium levels should be guided by the patient's underlying clinical conditions and dietary potassium and sodium intake. (Grade of Recommendation: C, based on case series.)

22-081 A randomized controlled trial of patient self-management of oral anticoagulation therapy compared with primary care management.

Fitzmaurice DA, Murray ET, Gee KM, et al. J Fam Pract. March 2001. Vol.50. No.3. p.248.
Reviewed by Dr Bruce Adlam
Review: This study has demonstrated that patient self-management is feasible within the United Kingdom primary care setting. It remains to be seen whether this model of care is generalisable to different environments and whether it will be cost-efficient compared with hospital practice.
Comment: This is a very small RCT, however, I know some practices are using Coaguchek (Roche Diagnostics) devices and it certainly has positive implications for rural practices that have limited access to laboratories or even telephone communication with their GP. (Published in the JFP as an abstract only.)

22-082 Does lipid lowering increase nonillness mortality?

Sweeney T, Odell C, Botler J, et al. J Fam Pract. April 2001. Vol.50. No.4. p.297.
Reviewed by Dr Bruce Adlam
Review: Though cholesterol-lowering therapy can reduce cardiovascular morbidity and mortality, earlier studies raised concerns that reducing cholesterol concentrations might increase the risk of cancer and deaths from suicides, accidents, and violence (i.e. nonillness mortality). This meta-analysis did not show a statistically significant relationship between cholesterol lowering and increased risk of non-illness mortality. (Original article reviewed: BMJ 2001; 322: 11-15.)

22-083 Cyclooxygenase inhibitors: any reservations?

Penglis PS, James MJ, Cleland LG. Intern Med J. Janurary/February 2001. Vol.31. No.1. p.37-41.
Reviewed by Dr Helen Moriarty
Review: A concise four page article on the cox-1 and cox-2 medications.

It explains the role of these inhibitors, and the thought processes behind the search for selective inhibition. It is now apparent that cox-2 selective inhibitors may have untoward side effects, because cox-2 may have a useful 'housekeeping' role in the absence of inflammation.

Comment: A good article for those who are confused about the roles of these two isoenzymes. Clinical bottom line? – that they have overlapping physiological as well as inflammatory effects.

Urology

22-084 The urgent call of albuminuria/proteinuria: heeding its significance in early detection of kidney disease.

Hebert LA, Spetie DN, Keane WF. Postgrad Med. October 2001. Vol.110. No.4. p.79-96.

Reviewed by Dr Chris Milne

Review: Proteinuria typically serves as the first evidence of progressive kidney disease. Benign orthostatic proteinuria (present when standing but not when recumbent) is a disorder of children and young adults. Mild proteinuria may be exercise related. In all cases, the doctor should first exclude kidney disease. It is important to consult early with a nephrologist. By the time the serum creatinine has climbed above the normal range, 80% of normal kidney function has been lost. Renoprotective strategies are best implemented early.

Comment: Very good article about a complex problem.

22-085 Asymptomatic microscopic hematuria in adults: summary of the AUA Best Practice Policy Recommendations.

Grossfeld GD, Wolf JS, Litwin MS, et al. Am Fam Physician. 15 March 2001. Vol.63. No.6. p.1145-54.

Reviewed by Dr J R Elliott

Review: An American Urological Association policy panel convened to formulate recommendations for the evaluation of asymptomatic microhaematuria in adults. Microhaematuria is defined and although it has a presence in normal patients, there is a range which includes urological malignancies. The intermittent nature of the findings are emphasised. Appropriate renal investigations are outlined.

Comment: A good attempt to clarify investigations into an often incidental finding. No clarification as to when to test for it.

A good flow chart for renal investigation and a list of renal disease risk factors suggests investigate all at risk of renal disease and follow-up mandatory in patients when investigation deferred. Nothing here you will not know already but confirms the dilemmas. Investigate or follow-up all!

Lessons from H & D C opinions

(continued from page 7)

patient to receive a script for a third generation OC without specifically being seen to review the contraception options. In particular, this was at a time when very real concern was being expressed about the increased incidence of thrombotic events. The patient had been seen within that time but for intercurrent illness, and no mention was made of discussion re risks of third generation OCs.

2 The GP failed to specifically recognise the recommendations coming from the Ministry of Health (MOH) and should have insisted that the woman have a consultation specifically to discuss the risks and record weight and blood pressure.

Please note that:

1 The repeat script was issued at a time when a locum was in place on more than one occasion; and
2 The woman had been instructed at an earlier visit that she should attend the surgery for a well woman's check but never did.

This is a tragic case where a young person has died possibly as a result of being on a third generation OC. The GP argued strongly that, yes the system had failed to warn the patient and allow her to make an informed choice, but the patient had not followed up advice to attend for a check up and rang for a repeat prescription without choosing to have a consultation. The medical advisors to the HDC varied in their responses to this case and the decision to find against the GP was in part based on the advice of an epidemiologist who reviewed the information from the MOH at that time.

This is a landmark case and the full transcript should be reviewed at peer group meetings around the country. The transcript is available on the Commisioner's web site www.hdc.org.nz. Issues that may be discussed:

1 Who would be liable if the woman had attended as directed, the risks of the medication explained and chose to stay on the OC and subsequently died?
2 Rules concerning the issuing of repeat prescriptions at a practice level. What is safe practise in this area and how do we balance the need of the GP to ensure safe prescribing with the wish of the patient to avoid the cost and inconvenience of a consultation?
3 The liability of the prescribing GP where a patient chooses not to follow advice about attending for a consultation.

The Health and Disability Commissioner (H DC) considered:

1 Both the GP *and the medical centre* breached right 4(1) and (2) in that the GP did not review the medication, contraindications and risk factors to ensure that the pre-

(continues over page)