Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Ann Intern Med *
Arch Intern Med*
Aust Fam Physician*
BMJ*
Br J Dermatol*
Br J Sports Med*
Can Fam Physician Med Fam Can*
Drug Alcohol Rev*
Eur J Pain*
Evidence-Based Medicine*
Int J Obes*
Intern Med J*
J Fam Pract*
JAMA*
Lancet*
N Engl J Med*
Neurol Sci*
Physician and Sportsmedicine*
Postgrad Med*
Sci Am*
*Journals indexed in Medline

Acupuncture

26-001 Different patterns of blood flow response in the trapezius muscle following needle stimulation (acupuncture) between healthy subjects and patients with fibromyalgia and work-related trapezius myalgia.

Sandberg M, Larsson B, Lindberg L, et al. Eur J Pain. October 2005. Vol.9. No.5. p.497-510.

Reviewed by Dr Alex Chan

Review: This study investigated the effects of deep muscle needling versus superficial needling on the local blood flow in the trapezius muscle and overlying skin in healthy subjects, in fibromyalgia and in work-related trapezius myalgia patients. Blood flow was found to be significantly increased in both areas in all three groups of participants post-intervention. However, in healthy subjects, more increase was noted with deep muscle needling and stimulation then superficial needling, while the opposite was true in fibromyalgia patients. There was no significant difference of the effects between the two forms of stimulation in patients with severely work-related trapezius myalgia.

Comment: This is another scientific investigation which showed that superficial needling is not inert. Therefore, caution should be exercised when interpreting results of acupuncture studies using superficial needling as placebo. In fibromyalgia patients, further investigations are required to show whether superficial needling will give better pain relieving effects than deep muscle needling.

26-002 A randomized clinical trial of acupuncture compared with sham acupuncture in fibromyalgia.

Assefi NP, Sherman KJ, Jacobsen C, et al. Ann Intern Med. 5 July 2005. Vol.143. No.1. p.10-9.

Reviewed by Dr Alex Chan

Review: The study compared the pain relieving effect of directed acupuncture to one of three sham acupuncture treatments for 12 weeks in 100 adults with fibromyalgia. Treatments were given twice weekly. There was no significant difference in pain rating (using a visual analogue scale) or total number of pain medications used among patients who received directed acupuncture and those who received sham acupuncture. The authors concluded that they did not find acupuncture reduced pain in patients with fibromyalgia.

Comment: Interesting study with innovative controls using three different forms of sham acupuncture – (1) by using a prescription which is

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The majority of reviewers are themselves general practitioners. A review in the JRS should not be considered a substitute for reading the original article.

The JRS seeks to extend the range of journals reviewed and always welcomes new reviewers.

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typically used for irregular periods, (2) using body locations not recognised as true acupuncture points or meridians, and (3) using a toothpick for non-insertive simulated acupuncture at the same acupoints used in directed acupuncture. Although the authors did not find significant difference of outcome measures among the sham acupuncture groups using complex statistical methods, readers could be impressed by the effects of toothpick acupuncture on pain intensity, fatigue intensity, sleep quality and overall well-being when looking at the graphical presentations. It could be that superficial or minimal stimulation is more effective in fibromyalgia than deep stimulation. An inclusion of 'usual treatment' group as control could have increased the validity of the study.

26-003 Ear acupuncture in the control of migraine pain: selecting the right acupoints by the 'needle-contact test'

Romoli M, Allais G, Airola G, et al. Neurol Sci. May 2005. Vol.26. No.Suppl 2. p.s158-61. Reviewed by Dr Alex Chan

Review: The authors presented a case report in which a patient with migraine was treated with acupuncture to a single ear acupoint selected by the 'needle contact test'. The technique involved detecting sensitive acupoints on the ear initially by the use of a pressure algometer. Their relative usefulness was then assessed by observing the effect on the migraine after placing an acupuncture needle in contact with the skin over the individual acupoints. The skin over the acupoint which gave maximal pain relief within 10 to 60 seconds was then penetrated by the needle which was left in place for 30 minutes.

Comment: A useful technique for selecting the optimal ear acupoint for treatment of migraine. This has probably already been used by some NZ medical acupuncturists for a few years.

Alcohol and Substance Abuse

26-004 Therapy preference and treatment outcome in clients with mild to moderate alcohol dependence.

Adamson SJ, Sellman JD, Dore GM. Drug Alcohol Rev. May 2005. Vol.24. No.3. p.209-16. Reviewed by Dr Helen Moriarty

Review: Patients were randomised to treatments, but asked if they had a preference of three options before being randomised. There was no difference in outcome for those who received their preferred treatment and those who did not. Authors conclude that it is OK to randomise patients to treatments regardless of their preference. There is an alternate explanation!

Comment: All three options were variants of brief therapy: two involved further counselling over and above written material and brief intervention (advice to cut down). Other papers have shown no advantage of brief therapy over brief intervention – and these authors have confirmed just that!

26-005 Validation of the World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): report of results from the Australian site.

Newcombe DA, Humeniuk RE, Ali R. Drug Alcohol Rev. May 2005. Vol.24. No.3. p.217-26. Reviewed by Dr Helen Moriarty

Review: A limitation of screening tests in drug and alcohol users is their focus on just alcohol or just drugs. ASSIST has eight questions, takes five minutes, covers drugs, alcohol and tobacco. For someone with past but not current use, the ASSIST shortens to five questions. This paper compares performance of ASSIST against a comprehensive battery of other tests, in 150 participants, fitting three profiles: current abstainers, current low level users, current high level users.

Comment: ASSIST looks promising as a quick, low cost, validated drug and alcohol screening tool for general practice.

26-006 Estimating the dollar value of the illicit market for cannabis in New Zealand.

Wilkins C, Reilly JL, Pledger M, et al. Drug Alcohol Rev. May 2005. Vol.24. No.3. p.227-34. Reviewed by Dr Helen Moriarty

Review: Data used from the National Drug Survey 2001 to calculate the dollar value of the market from self reports on prevalence, procurement, frequency and weight of purchase. The calculations included many assumptions, but give a rough picture of the market value, varying from $5 per year to $55,200 per year, average $1,313 per year but median $400.

Comment: Such information is mainly of interest to policy-makers, and then only for following trends.

This ensures that the authors can get another paper on the same methodology at a later rate – watch out for the 2003 National Drug Survey results to be used for this purpose!

26–007 The medical complications of alcohol use: understanding mechanisms to improve management.

Chase V, Neild R, Sadler CW, et al. Drug Alcohol Rev. May 2005. Vol.24. No.3. p.253-65.
Reviewed by Dr Helen Moriarty

Review: A discussion paper that covers known mechanisms for the many medical consequences of alcohol. A comprehensive review, well written. Also discusses the management of organ damage from alcohol.

Comment: Worthwhile reading!

26–008 From opioid maintenance to abstinence: a literature review.

Kornor H, Waal H. Drug Alcohol Rev. May 2005. Vol.24. No.3. p.267-74.
Reviewed by Dr Helen Moriarty

Review: What happens when patients on opioid maintenance decide to stop? This paper summarises the literature on patient follow-up after coming off methadone maintenance. Most studies are naturalistic – describing follow-up without a specific research design. Follow-up periods vary from one to 103 months. Abstinence rates are consistently low, varying from 22–86% by self report, and detox process not well described.

Comment: This paper highlights the need to systematically study what happens to patients who come off methadone maintenance. Too often patients lose contact with services once they no longer require regular prescriptions.

26–009 The relationship between take-away methadone policies and methadone diversion.

Ritter A, Di Natale R. Drug Alcohol Rev. July 2005. Vol.24. No.4. p.347-52.
Reviewed by Dr Helen Moriarty

Review: This paper illustrates the risk of take-away methadone doses: that they will be injected. An annual survey of Australian drug users provided information on injecting behaviour. Australian states do have variable policies on take-away methadone doses. In Victoria and WA only one take-away dose per week is ever allowed.

Comment: Is New Zealand too free with take-away methadone? Are GPs taken for a ride by trusted GP scripted patients who have three or more take-away doses a week? State regulation restricts such 'freedom' in OZ, except in Tasmania and Queensland. Time to rethink?

Cardiovascular System

26–010 What is the evaluation and treatment strategy for Raynaud's phenomenon?

Tagliarino H, Purdon M, Jamieson B. J Fam Pract. June 2005. Vol.54. No.6. p.553-5.
Reviewed by Dr Bruce Adlam

Review: Nice article indicating how history plays a key role in distinguishing primary from secondary Raynaud's phenomenon. The initial treatment includes obvious conservative measures such as the use of gloves, cold avoidance, rapid rewarming, supports in refractory cases, and the judicious use of nifedipine or prazosin to alleviate symptoms.

26–011 Does digoxin decrease morbidity for those in sinus rhythm with heart failure?

Fotinos C, Nashelsky J. J Fam Pract. June 2005. Vol.54. No.6. p.556-7.
Reviewed by Dr Bruce Adlam

Review: This useful article brings together evidence from Cochrane review and recommendations from the big cardiology colleges and associations in US and Europe. They agree ACE inhibitors, diuretics, and beta-blockers should all be the first drugs chosen for therapy for patients with CHF. They have not only been shown to improve mortality and reduce symptoms but they do not carry any of the significant risks associated with digoxin toxicity. Digoxin is unlikely to benefit patients with Class I heart failure, as their risk of clinical deterioration and hospitalisations are low. However, for patients who cannot tolerate any of the first-line drugs or who remain symptomatic while taking them, digoxin carefully dosed and monitored is a useful adjunct in practice.

26–012 Lipid drugs have varying effects on overall mortality.

J Fam Pract. July 2005. Vol.54. No.7. p.577.
Reviewed by Dr Bruce Adlam

Review: Strong words and clear recommendations from this large meta analysis. Only statin lipid-lowering drugs have been shown to decrease overall mortality for patients with high cholesterol but without evidence of heart disease. However, most patients treated with one of these drugs do not benefit: 228 have to be treated for 3.3 years to prevent one additional death during this period. (Original article reviewed see 26-013)

Comment: For patients with known heart disease, statins and fish oil both have been shown to decrease mortality. Niacin, resins, and diet have not been shown to decrease mortality. Fibrates (gemfibrozil and others) actually increase overall mortality and at the same time decrease cardiac mortality. (Level of evidence: 1a).

26–013 Effect of different antilipidemic agents and diets on mortality.

Studer M, Briel M, Leimenstoll B, et al. Arch Intern Med. 11 April 2005. Vol.165. No.7. p.725-30.
Reviewed by Dr Bruce Adlam

Review: See 26-012.

26–014 Early invasive versus selectively invasive management for acute coronary syndromes.

de Winter RJ, Windhausen F, Cornel JH, et al. N Engl J Med. 15 September 2005. Vol.353. No.11. p.1095-104.
Reviewed by Dr Raina Elley

Review: This is a pivotal randomised controlled trial, which questions the evidence behind guidelines that recommend early invasive treatment (coronary angiography, and revascularisation where indicated soon after presentation) in people presenting with acute coronary syndrome without ST elevation, but with raised serum troponin. One thousand two hundred patients were enrolled between 2001 and 2003 to receive early invasive treatment or a more conservative selectively invasive strategy. All participants were given ideal medical treatment. While many of those in the more conservative group did receive revascularisation within one year (54% compared with 79%), only 4% received a revascularisation procedure within two days compared with 56% in the early invasive group. When outcomes were assessed, there was no significant difference in mortality of combined outcomes between the two groups, but significantly more myocardial infarctions in the early invasive group.
Comment: Surgical revascularisation is frequently assumed to be of benefit to those with IHD and significant coronary vessel disease despite equivocal evidence in some scenarios, or only small benefit. This trial provides another example (non-STEMI) where an early invasive approach was not of benefit and there was even evidence of increased harm compared with a more conservative medical approach.

26-015 Training effects of short bouts of stair climbing on cardiorespiratory fitness, blood lipids, and homocysteine in sedentary young women.

Boreham CA, Kennedy RA, Murphy MH, et al. Br J Sports Med. September 2005. Vol.39. No.9. p.590-3.
Reviewed by Dr Chris Milne
Review: This study demonstrated that a progressive stair climbing programme not only improved VO2 max, but also reduced LDL cholesterol. The young women in the study enrolled in an eight week programme, and by the last two weeks were completing five bouts of stair climbing, per day on five days per week.
Comment: Stair climbing requires no specialised facilities or equipment, and seems to be an efficient and well tolerated way of influencing cardiovascular risk factors.

26-016 Treating non-ST-segment elevation ACS: Pros and cons of current strategies.

Carbajal EV, Deedwania P. Postgrad Med. September 2005. Vol.118. No.3. p.23-32.
Reviewed by Dr Chris Milne
Review: Non ST segment acute coronary syndrome is diagnosed in patients with a clinical picture consistent with acute ischaemic symptoms, and new ECG changes showing ST segment depression, T wave inversion or both. In addition, there may be elevation of cardiac enzymes. In low risk patients, aspirin, beta blockers, smoking cessation, an exercise programme and optimising of diet is recommended. High risk patients may require coronary angiography.
Comment: Useful article on an important condition. The algorithms are helpful, and for the obsessional, there is a good summary of the trial data.

26-017 Habitual caffeine intake and the risk of hypertension in women.

Winkelmayer WC, Stampfer MJ, Willett WC, et al. JAMA. 9 November 2005. Vol.294. No.18. p.2330-5.
Reviewed by Dr Raina Elley
Review: The Nurses Health Studies (NHS I and II) have a combined sample size of more than 150 000 over 12 years. There have been many analyses carried out on this data. Here is another. Caffeine consumption is associated with an acute rise in blood pressure. To look at long-term effects, coffee and caffeine consumption were recorded prospectively in the NHSs. After adjustment for multiple demographic and risk factors, habitual coffee drinking was not a risk factor for hypertension (although there may be a U-shaped association). However, consumption of other caffeinated drinks (such as sugared or diet colas) were associated with increased risk of hypertension after adjustment for multiple risk factors.
Comment: Like other hypothesized risk factors (e.g. alcohol) there appeared to be a U-shaped relationship between consumption of coffee and development of hypertension. Perhaps this says more about the benefit of a 'moderation' approach to life than the beverage or behaviour being tested. Observational studies (non-experimental) can only ever look at associations, not causal relationships.

26-018 Effects of protein, monounsaturated fat, and carbohydrate intake on blood pressure and serum lipids: results of the OmniHeart randomized trial.

Appel LJ, Sacks FM, Carey VJ, et al. JAMA. 16 November 2005. Vol.294. No.19. p.2455-64.
Reviewed by Dr Raina Elley
Review: This was a crossover randomised controlled trial of three dietary regimes (high carbohydrate, high protein and high unsaturated fats). All three had low saturated fat. There were 164 mildly or pre- hypertensive participants who completed all three regimes (random order) each regime lasting six weeks with two to four weeks wash-out in between. Weight was held steady. Main outcomes included systolic and diastolic blood pressure, lipid profiles and cardiovascular risk. Compared with the high carbohydrate diet, the high protein diet and the high-unsaturated fat diet significantly reduced systolic and diastolic blood pressure amongst hypertensive participants, and improved lipid profiles and cardiovascular risk. Both these diets had favourable effects on triglycerides and total cholesterol, compared with the high carbohydrate diet. The high protein diet also reduced LDL, while the high fat diet improved HDL. (See also 26-019)

Comment: The results of this trial (and a growing number of other trials) are questioning our traditional approach to weight-loss and weight maintenance, which advises low fat and relatively high carbohydrate. Controversial diets such as the Atkins diet or high protein diets have had limited evidence, with variable adherence with diets in trials. Differential adherence makes interpretation of the effects on lipid profiles, in particular, very difficult. The content of the three diets in this trial is very interesting. For example, a large component of the protein diet is of plant origin (e.g. soy). This trial was very good quality. While it did not use an intention to treat analysis (191 were randomised), it carried out multiple sensitivity analyses that imputed values for missing follow-up data, which did not significantly change the results. The trial is very short, however (six weeks for each regime), so a longer parallel trial would be reassuring that these cardiovascular benefits were sustained. Unfortunately, such a trial may run into problems of differing adherence and therefore difficult to interpret.

26-019 More novel effects of diet on blood pressure and lipids.

Weinberger MH. JAMA. 16 November 2005. Vol.294. No.19. p.2497-8.
Reviewed by Dr Raina Elley
Review: (See also 26-018)

26-020 The end of beta blockers for uncomplicated hypertension?

Beevers DG. Lancet. 29 October 2005. Vol.366. No.9496. p.1510-2.
Reviewed by Dr Tony Hanne
Review: The recent ASCOT-BPLA study attracted worldwide attention by demonstrating that an ACE inhibitor and a calcium channel blocker separately or together were better than atenolol and a thiazide in preventing stroke and no worse at preventing myocardial infarction in primary hypertension. This commentary discusses the implications of this and a further meta-analysis confirming the same conclusion. Guideline groups should rethink their recommendation of B-blockers as first line treatment because the evidence does not support this advice. At the same time B-blockers still have a place after infarction, in angina, heart failure and some arrythmias including atrial fibrillation. (See also 26-021).
Comment: Don't throw the baby out with the bathwater! Many patients will still benefit from B-blockers, but not for primary hypertension.

26-021 Should Beta blockers remain first choice in the treatment of primary hypertension? A meta-analysis.

Lindholm LH, Carlberg B, Samuelsson O. Lancet. 29 October 2005. Vol.366. No.9496. p.1545-53.
Reviewed by Dr Tony Hanne
Review: (See also 26-020)

26-022 Obesity and the risk of myocardial infarction in 27 000 participants from 52 countries: a case-control study.

Yusuf S, Hawken S, Ounpuu S, et al. Lancet. 5 November 2005. Vol.366. No.9497. p.1640-9.
Reviewed by Dr Tony Hanne
Review: The real cardiovascular risk is from abdominal obesity. For many years we have used Body Mass Index (BMI) as one predictor of risk. Waist circumference is a better predictor than BMI but waist to hip ratio is better still. BMI normals have been based largely on European populations. In 27 000 patients from a wide range of ethnic origins, the consistent usefulness of the waist to hip ratio as compared with BMI was demonstrated. Each quintile increase showed a stronger effect. The possible reasons for the importance of abdominal obesity and the protective effect of limb musculature are discussed. (See also 26-023).
Comment: Those of us in general practice with a wide range of ethnicity among our patients have been frustrated for years by the observation that Asian people could be obese and still have a reasonable BMI and on the other hand no Samoan patient ever seemed to have a BMI under 25. Limb musculature obviously relates to exercise and offers further support for the protective effect of regular exercise.

26-023 A farewell to body-mass index?

Kragelund C, Omland T. Lancet. 5 November 2005. Vol.366. No.9497. p.1589-91.
Reviewed by Dr Tony Hanne
Review: (See also 26-022)

Cerebrovascular System

26-024 Aspirin prevents stroke, not MI, in women.

J Fam Pract. July 2005. Vol.54. No.7. p.584.
Reviewed by Dr Bruce Adlam
Review: Aspirin reduces the risk of stroke and transient ischemic attack in women in this primary prevention study, but does not reduce the risk of myocardial infarction or cardiovascular death. The reduction in strokes over 10 years (number needed to treat = 444) must be balanced against an increase in serious gastrointestinal bleeds (number needed to treat to harm = 553). No change was seen in this large, long study regarding all-cause mortality. (Level of evidence: 1b) (Original article reviewed see 26-025).

26-025 A randomized trial of low-dose aspirin in the primary prevention of cardiovascular disease in women.

Ridker PM, Cook NR, Lee IM, et al. N Engl J Med. 31 March 2005. Vol.352. No.13. p.1293-304.
Reviewed by Dr Bruce Adlam
Review: See 26-024.

Communicable Diseases, Infections and Parasites

26-026 Fear of avian influenza is a double-edged sword.

Lancet. 19 November 2005. Vol.366. No.9499. p.1751.
Reviewed by Dr Tony Hanne

Review: *'To fear the worst oft cures the worst'*, wrote William Shakespeare. This is probably true of the effect on government planners anticipating avian flu spreading from human to human who have been galvanised into endless studies, meetings and news conferences. If and when the time comes they should perform better although there are still many unanswered questions. This editorial suggests however that the near panic generated among the public in some countries by the doomsday predictions on which the news media flourish could undermine even the best planning.

Comment: Calm common sense advice about how to minimise danger could be more useful than a panicky debate about who is worth saving with a limited supply of Tamiflu. Apparently in the 1918–19 influenza epidemic, Coromandel had no cases at all because they closed the bridge at Thames.

26-027 A varicella-zoster virus vaccine reduced the burden of illness of herpes zoster in older adults.

Fekete T. Evidence-Based Medicine. December 2005. Vol.10. No.6. p.177.
Reviewed by Dr Bruce Arroll

Review: This was a randomised trial in patients who were older than 60 years, had an episode of varicella or lived in the US for more than 30 years. The result was surprising in that there was a benefit with a numbers needed to treat of 59 to prevent a new case of shingles and an NNT of 364 to prevent a case of post herpetic neuralgia. (Original article reviewed: N Engl J Med 2005; 352:2271-84).

Comment: The commentator said: *'For this new vaccine, the optimal age at first administration still needs to be determined. The duration of protection is unknown. While the relatively high NNT of 59 may seem unappealing, a vaccine with 100% protection against zoster would still have an NNT of 30.'*

Dermatology

26-028 Once-daily topical steroid dosing effective for atopic eczema.

J Fam Pract. June 2005. Vol.54. No.6. p.499-500.
Reviewed by Dr Bruce Adlam

Review: This meta analysis of randomised controlled trials shows little support for dosing more than once a day. (Original article reviewed see 26-029).

26-029 Topical corticosteroids for atopic eczema: clinical and cost effectiveness of once-daily vs more frequent use.

Green C, Colquitt JL, Kirby J et al. Br J Dermatol. January 2005. Vol.152. No.1. p.130-41.
Reviewed by Dr Bruce Adlam

Review: See 26-028.

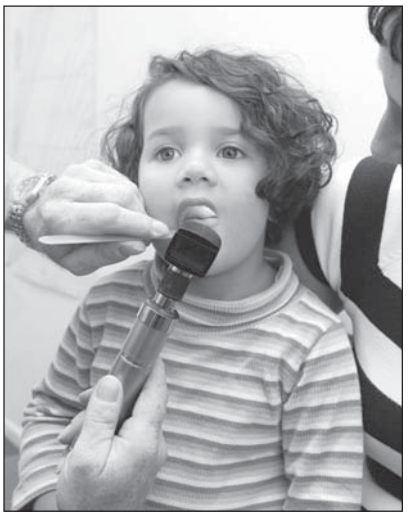
Ear, Nose and Throat

26-030 Review: treatment with ventilation tubes has little effect in children with otitis media with effusion.

Paton JY. Evidence-Based Medicine. December 2005. Vol.10. No.6. p.175.
Reviewed by Dr Bruce Arroll

Review: This was a review of all the randomised trials of ventilation tubes for otitis media with effusion. There was an improvement in hearing at six months but not at 12 months. (Original article reviewed: Arch Dis Child 2005; 90: 480-5).

Comment: The commentator said *'against both expectation and usual guidance, those with greater hearing impairment did not show significantly more improvement. There were too few participants in high risk subgroups (e.g. children with cleft palate or learning problems) for meaningful analysis. So, at present, the evidence favours watchful waiting for normal children with persistent OME – at least until larger RCTs with adequate numbers of high risk children become available.'*



Emergency Medicine

26-031 Why do acute myocardial infarction patients not call an ambulance? An interview with patients presenting to hospital with acute myocardial infarction symptoms.

Lozzi L, Carstensen S, Rasmussen H, et al. Intern Med J. November 2005. Vol.35. No.11. p.668-71.
Reviewed by Dr Helen Moriarty

Review: Two hundred and fifteen patients presenting to ED with AMI symptoms were interviewed. Some had arrived by ambulance and others used their own transport. When asked, those using own transport thought they were not ill enough to call an ambulance, or wanted to go to the tertiary hospital rather than the nearest facility. Some had gone to see their GP first. Even some with known CHD did so.

Comment: Calling an ambulance can be life-saving, and it seems to be this message that the general public has not taken on board. As a hospital (ED)-based study this might give a selectively biased perspective on the entire picture of patient choice under such circumstances.

26-032 New international consensus on cardiopulmonary resuscitation.

Chamberlain D. BMJ. 3 December 2005. Vol.331. No.7528. p.1281-2.

Reviewed by Dr Len Brake

Review: The 'mouth-to-mouth' aspect of CPR seems to becoming less important over time. The ratio of chest compressions to breaths is now 30 to two. At this rate we will be back with the 'Holger-Neilson artificial respiration' we learnt at school for the lifesaving medal. The victim was laid prone with head to one side. The lifesaver knelt at their shoulder. The airways were cleared largely by the chest compression. There was no mouth contact at all. The expired air CPR became the vogue in the early 1960s. The new recommendations are: (a) CPR with chest compression to ventilation ratio of 30:2, (b) No initial ventilation before starting compressions, (c) When professional help is delayed for more than four to five minutes one option is to give compressions for up to three minutes before attempting defibrillation, (d) Compressions for two minutes after defibrillation, (e) Second and further defibrillation given only after additional cycles of chest compression.

Evidence-Based Medicine

26-033 Cautionary tales in the clinical interpretation of therapeutic trial reports.

Scott A, Greenberg PB. Intern Med J. October 2005. Vol.35. No.10. p.611-21.

Reviewed by Dr Helen Moriarty

Review: This paper gives examples of clinical trial data which has been inadvertently misapplied to become routine clinical practice when the evidence did not support that. The results can be disastrous. A particular hazard is use of inappropriate endpoints, composite combinations or surrogates, and small subgroups such that NNT do not apply.

Comment: Bottom line is: beware of generalisability, faulty comparators (not equivalent in dose-response), surrogate endpoints that do not match important clinical endpoints, relative versus absolute risks, small group analysis and small effect sizes.

Family Practice

26-034 Early experience with pay-for-performance: from concept to practice.

Rosenthal MB, Frank RG, Li Z, et al. JAMA. 12 October 2005. Vol.294. No.14. p.1788-93.

Reviewed by Dr Raina Elley

Review: This study compares the outcomes of using a 'pay-for-performance' (California physician groups) with no payments for performance approach (Pacific Northwest physician groups) to community-based physician care over two and a half years. Quality outcome measures included improvements in cervical screening rates, mammography and HbA1c. The only significant difference in improvement was cervical screening where rates improved by 5.3% in California groups compared with 1.7% in the Pacific Northwest (p=0.02). US$3.4 million was spent on these payments, mostly to those who had already reached the target at baseline and who were least likely to improve because they started at such a high level. The authors conclude that this approach does not produce significant improvements for the resources invested and mainly rewards those with the highest performance at baseline. (See also 26-035).

Comment: While this is an interesting conclusion and may be valid to the approaches that many primary care organisations and quality improvement plans around New Zealand, there should be some caution placed around the findings of this study. This was a retrospective analysis of a 'natural experiment' (i.e. not randomised). There may have been many other regional or organisational influences that changed practice and the three quality markers. An alternative approach to avoid rewarding those that are already achieving, is to reward for improvement. However, this penalises the practices that have already achieved, and are sustaining, a high level of care. Perhaps a more rigorous analysis would be a RCT and cost-effectiveness study of pay-for-performance (PFP), compared with other approaches to improving quality of care. That may be too logistically difficult, but a similar analysis to this study looking at NZ primary care organisations (PCO) would be interesting. However, those PCOs that used a PFP approach may well have been more innovative in other ways, which contaminates your analysis.

26-035 Pay-for-performance research: How to learn what clinicians and policy makers need to know.

Dudley RA. JAMA. 12 October 2005. Vol.294. No.14. p.1821-3.

Reviewed by Dr Raina Elley

Review: (See also 26-034)

Gastroenterology

26-036 Review: prompt endoscopy is not a cost effective strategy for initial management of dyspepsia.

Talley NJ. Evidence-Based Medicine. December 2005. Vol.10. No.6. p.185.

Reviewed by Dr Bruce Arroll

Review: In the initial management of dyspepsia prompt endoscopy was slightly more effective but not cost effective compared with a test and treat approach for inducing resolution of symptoms. (Original article reviewed: Gastroenterology 2005; 128: 1838-44).

Comment: The commentator on this paper said: *'The H. pylori test and treat strategy was equally good in those with predominant epigastric pain or heartburn, suggesting that distinguishing management of dyspepsia from gastroesophageal reflux disease may be somewhat artificial. While this analysis cannot capture other dimensions of prompt endoscopy*

that may be of value, including reassurance to patient and physician, overall, test and treat should remain the standard of care for management of uninvestigated dyspepsia.'

General

26-037 Pet ownership and human health: a brief review of evidence and issues.

McNicholas J, Gilbey A, Rennie A, et al. BMJ. 26 November 2005. Vol.331. No.7527. p.1252-4.
Reviewed by Dr Len Brake

Review: Research from the 1980s popularised the view that pet ownership was almost as good as having your own defibrillator on legs (or wings) such was the higher survival rate from myocardial infarcts in pet owners. Reduced risk of asthma in children, psychological well-being better than being on Prozac – it was becoming compulsory for pets to appear in rest homes and daycares.

Comment: Funnily enough 'recent studies have failed to replicate these benefits". There is evidence in fact to show the reverse of the rosy picture of the 1980's research. This is an interesting study looking at all aspects of pets and humans. Some dogs are able to detect bladder cancer and warn of an impending epileptic fit or hypoglycaemic attack – other dogs do not, as we know, learn new tricks.

26-038 Series, PowerPoint slides, and folders now available on bmj.com.

Delamothe T. BMJ. 24 September 2005. Vol.331. No.7518. p.650.
Reviewed by Dr Len Brake

Review: Three new services have been added to the *BMJ* website. A button on the homepage labelled 'series' takes users to a page with links to the 35 ABC series and other series such as '10 minute consultations' etc. The second feature allows users to obtain PowerPoint slides from *BMJ* illustrations. The other innovation is folders. Users can file articles under their own labelled folders. These services are free although access to full text and illustrations depends on user's access rights.

26-039 Neurobehavioural performance of residents after heavy night call vs after alcohol ingestion.

Arnedt JT, Owens J, Crouch M, et al. JAMA. 7 September 2005. Vol.294. No.9. p.1025-33.
Reviewed by Dr Raina Elley

Review: Work-related sleep-loss has been implicated in 'post-call' performance deficits, more errors and more accidents and near-crashes. This study assessed 34 paediatric registrars over time, comparing their *'sustained attention, vigilance, and simulated driving performance measures; and self-report sleepiness, performance, and effort measures'* following four regimes, using a repeated battery of tests. The regimes included light call, heavy call (>1 in four or five), light call plus alcohol (0.04 to 0.05 g% per 100 mL of blood), and heavy call plus placebo. The study found that heavy call did slow reaction times (7%), and that this was not always recognised by the participant. Commission errors were 40% higher, and speed and lane variability were both higher on the driving simulator compared with light call. The latter effects were more recognised by the participants themselves. When the heavy call and placebo were compared with light call and alcohol, impairment of most outcomes was similar in the two groups, but there was more speed variability after the heavy call regime. The authors conclude that post-call performance is significantly impaired and similar to the effects of alcohol and that participants did not always recognize this impairment. (See also 26-040 and 26-041).

Comment: Doctors in many fields undertake regular on-call requirements. The after effects and impaired clinical performance should be taken into account when setting on-call rosters, particularly in rural general practice where on-call requirements are often heavy.

26-040 Effects of work hour reduction on residents' lives: a systematic review.

Fletcher KE, Underwood W, Davis SQ, et al. JAMA. 7 September 2005. Vol.294. No.9. p.1088-100.
Reviewed by Dr Raina Elley

Review: (See also 26-039 and 26-041)

26-041 Work hours and reducing fatigue-related risk: good research vs good policy.

Dawson D, Zee P. JAMA. 7 September 2005. Vol.294. No.9. p.1104-6.
Reviewed by Dr Raina Elley

Review: (See also 26-039 and 26-040)

Gynaecology

26-042 Commentary: What's the deal with menopause management? Why the Women's Health Initiative raises more questions than it answers.

Richardson MK. Postgrad Med. August 2005. Vol.118. No.2. p.21-6.
Reviewed by Dr Chris Milne

Review: Following publication of the Women's Health Initiative (WHI) study in 2002, there has been a sea change in menopause care and estrogen use. WHI told us that it is not right to treat the population of postmenopausal women with conjugated estrogens alone, or in combination with medroxyprogesterone to prevent heart disease. The trial did not say estrogen has no role in the therapeutic armamentarium of physicians treating midlife women.

Comment: Interesting perspective on a controversial area.

Metabolic Diseases

26-043 What is the best strategy for impaired glucose tolerance in nonpregnant adults?

Rao S, Kakkar S, Wilder L. J Fam Pract. June 2005. Vol.54. No.6. p.543-6.
Reviewed by Dr Bruce Adlam

Review: The best treatment strategy for impaired glucose tolerance and impaired fasting glucose is lifestyle intervention with a structured weight loss programme of diet and exercise: (5%–7% weight loss and ~ 150 minutes moderate activity per week). Medications may have a role but lifestyle interventions appear superior. Several well designed studies show a greater than 10% absolute risk reduction in the progression to diabetes in lifestyle intervention groups compared with placebo.

26-044 Biomarkers and potential mechanisms of obesity-induced oxidant stress in humans.

Vincent HK, Taylor AG. Int J Obes. 22 November 2005. Vol.Early Online. p.1-19.
Reviewed by Dr Anne-Thea McGill

Review: This long, comprehensive article is unashamedly presented as a resource covering a moderately basic-science-approach to the metabolic syndrome. Although it reviews the oxidative stress evidence of obesity, it's surprisingly wide-ranging explanation covertly and overtly suggests why and what physical treatments work.

Comment: I agree that oxidative stress is the mostly likely explanation bringing the metabolic markers together in abdominal obesity. However, the last part, although cautioning on the need for more research and on the excessive use of synthetic antioxidants shown in some studies to become pro-oxidant in those with high CVD risk, is perhaps a little too supportive of supplements over a high fruit and vegetable intake.

Musculoskeletal System

26-045 Shoulder pain: diagnosis and management in primary care.

Mitchell C, Adebajo A, Hay E, et al. BMJ. 12 November 2005. Vol.331. No.7525. p.1124-8.
Reviewed by Dr Len Brake

Review: For those who are counting, shoulder pain is the third most common cause of musculoskeletal consultation in primary care. For those who appreciate extreme degrees of understatement the introduction continues: *'recent studies suggest that chronicity and recurrence are common'*. This study is a summary of an extensive literature search including 'shoulder pain' looking at diagnosis and intervention. The four common causes of shoulder pain in primary care are rotator cuff disorders, glenohumeral disorders, acromioclavicular disorders and referred neck pain. The most common is rotator cuff damage.

Comment: Treatment of value is very thin on the ground: rest and paracetamol is helpful. Physiotherapy, steroid injections seem borderline in effectiveness and the recent rush of rotator cuff surgery is being done with no evidence of long-term benefits. Surgery should only be considered when conservative measures fail.

Neurology

26-046 Melatonin effective for some sleep disorders.

J Fam Pract. June 2005. Vol.54. No.6. p.493.
Reviewed by Dr Bruce Adlam

Review: The authors of this systematic review found melatonin in doses from 0.1mg to 10mg is effective in helping adults and children who have difficulty falling asleep. It is particularly helpful in patients whose circadian rhythm is permanently off-kilter (delayed sleep phase syndrome). It increases sleep length, but not sleep quality, in patients who perform shift work or who have jet lag. (Original article reviewed: Melatonin for treatment of sleep disorders. Evidence Report/Technology Assessment No. 108. AHRG Publication No. 05-E002-1. Available online at http://www.ahrq.gov/downloads/pub/evidence/pdf /melatonin/melatonin.pdf)

26-047 Complex regional pain syndrome underdiagnosed: CRPS type 1 is an under-recognized problem in limbs recovering from fracture or immobilized post-stroke.

Quisel A, Gill JM, Witherell P. J Fam Pract. June 2005. Vol.54. No.6. p.524-32.
Reviewed by Dr Bruce Adlam

Review: Quite a lengthy review of the diagnosis of this syndrome but rather light weight recommendations on management. Key points are that complex regional pain syndrome (CRPS) may be diagnosed by history and physical exam with no further testing. Several different diagnostic criteria have undergone validity testing (Bruehl's, and Veldman's criteria). None is recommended over the other.

Comment: There is some support for early inpatient rehabilitation for post stroke CRPS in shoulder-hand syndrome and the use of vitamin C in preventing CPRS following fractures starting upon diagnosis of fracture and continued through healing.

26-048 Complex regional pain syndrome: Which treatments show promise?

Quisel A, Gill JM, Witherell P. J Fam Pract. July 2005. Vol.54. No.7. p.599-603.
Reviewed by Dr Bruce Adlam

Review: Treatments for CRPS type 1 supported by evidence of efficacy and little likelihood for harm are: topical DMSO cream (SOR: B), IV bisphosphonates (SOR: A) and limited courses of oral corticosteroids (SOR: B). Despite some contradictory evidence, physical therapy and calcitonin (intranasal or intramuscular) are likely to benefit patients with CRPS type 1 (SOR: B). Due to modest benefits and the invasiveness of the therapies, epidural clonidine injection, intravenous regional sympathetic block with bretylium and spinal cord stimulation should be offered only after careful counselling (SOR: B). Therapies to avoid due to lack of efficacy, lack of evidence, or a high likelihood of adverse outcomes are IV regional sympathetic blocks with anything but bretylium, sympathetic ganglion blocks with local anesthetics, systemic IV sympathetic inhibition, acupuncture, and sympathectomy (B).
Comment: The authors acknowledge pain management starts with oral or topical medications typically used for other neuropathic pain conditions (e.g. amitriptyline [Elavil], gabapentin [Neurontin], opioids, and nonsteroidal antidepressants).

26-049 Do statins delay onset or slow progression of Alzheimer's dementia?

Suchecki SA, Aitken PV, Potts R, et al. J Fam Pract. July 2005. Vol.54. No.7. p.626-7.
Reviewed by Dr Bruce Adlam
Review: Large randomised control trials found that the administration of a statin had no significant effect on preventing or slowing all-cause cognitive decline (strength of recommendation: A). There is insufficient evidence that statins delay the onset or slow the progression of Alzheimer's dementia. Three epidemiologic studies have found a decreased incidence of dementia among those taking statins, these studies have significant methodological shortcomings and do not show a causal relationship.

Obstetrics

26-050 Intrauterine growth restriction: diagnosis and management.

Sheridan C. Aust Fam Physician. September 2005. Vol.34. No.9. p.717-23.
Reviewed by Dr Rachel Monk
Review: This is quite an in-depth article on the potential causes of babies being small. Detection of this is obviously important and this article has clear guides for assessing pregnant women with this in mind. Finally management is discussed, although possibly in more depth than is required for general practice.
Comment: Certainly of interest to those still doing some obstetrics and probably to others, after all we all potentially have involvement in that first 13 weeks and in the preconception period.

26-051 Recognition and management of perinatal depression in general practice: a survey of GPs and postnatal women.

Buist A, Bilszta J, Barnett B, et al. Aust Fam Physician. September 2005. Vol.34. No.9. p.787-90.
Reviewed by Dr Rachel Monk
Review: Research article looking at ways to improve detection and then management of perinatal depression. The authors have recognised several limitations to the study but confirmed that women find depression hard to recognise in themselves, and that unless mood is enquired about many cases of depression will not be diagnosed.

Oncology

26-052 Cervical cancer, human papillomavirus, and vaccination.

Lowndes CM, Gill ON. BMJ. 22 October 2005. Vol.331. No.7522. p.915-6.
Reviewed by Dr Len Brake
Review: One of the trials of vaccines against HPV is reported. Other large trials are underway. The WHO is expecting one of these vaccines to be licensed for use in 2006. The latest data involving 12 167 women at 90 centres in 13 countries show a reported efficacy at 17 months follow-up of 100%. This is an editorial update of up-to-date knowledge on the subject.
Comment: Well worth a read - especially as patient interest is high. There are more than 100 types of HPV. Although cervical cancer is a rare consequence of HPV infection, the incidence of HPV infection is so high in sexually active women that worldwide, cervical cancer remains the 2nd most common cancer among women after breast cancer. The important questions such as who to vaccinate first are listed and these raise controversial issues such as 'Should teenage boys be vaccinated?'

26-053 Causes of cancer in the world: comparative risk assessment of nine behavioural and environmental risk factors.

Danaei G, Hoorn SV, Lopez AD, et al. Lancet. 19 November 2005. Vol.366. No.9499. p.1784-93.
Reviewed by Dr Tony Hanne
Review: Mortality rates for cardiovascular disease fell substantially during the 1990s because of preventative measures and better treatment. Rates for cancer fell to a lesser extent almost entirely due to prevention and screening and only marginally because of advances in treatment despite a huge investment in research into new therapies. The extent to which cancers are caused by nine environmental and behavioural factors were analysed looking particularly at the differences between developed and developing countries. Collectively smoking, alcohol, obesity, and low fruit and vegetable intake, physical inactivity, unsafe sex, and use of contaminated needles, urban and household air pollution account for over 1/3 of the 7 million deaths annually from cancer. For obvious reasons without cervical screening, deaths due to HPV were higher in poor countries, and obesity is more significant in rich countries.

Comment: If we are serious about making a difference to cancer deaths much more could be achieved by education, screening and legislation. GPs and practice nurses supporting parents are by far the most effective people in changing behaviour beginning among the young.

26-054 Management of early breast cancer: the current approach.

Brennan M, Wilcken N, French J, et al. Aust Fam Physician. September 2005. Vol.34. No.9. p.755-60.
Reviewed by Dr Rachel Monk

Review: Nice little update on treatment of early stage breast cancer.
Comment: Although GPs are usually not involved in the front line treatment they're still part of the multidisciplinary team, and often the first contact for patient questions, so it's good to be informed with the updated information.

26-055 Monitoring after childhood cancer: an update for GPs.

Heath JA. Aust Fam Physician. September 2005. Vol.34. No.9. p.761-7.
Reviewed by Dr Rachel Monk

Review: This article is a very useful update looking into the issues that need to be addressed in children following treatment for cancer. Included are some specific and general issues which need to be addressed / monitored.
Comment: I found this article extremely interesting. Lots of things that I would have not previously thought to assess are mentioned.

26-056 Radical prostatectomy reduced death and progression more than watchful waiting in early prostate cancer.

Munro AJ. Evidence-Based Medicine. December 2005. Vol.10. No.6. p.168.
Reviewed by Dr Bruce Arroll

Review: This was a randomised controlled trial started 20 years ago and treatment has changed since then. It found radical prostatectomy was more effective in reducing mortality than watchful waiting with a numbers needed to treat of 18. Radical prostatectomy was not effective in men over the age of 65 years in reducing mortality. (Original article reviewed: N Engl J Med 2005; 352: 1977-84)
Comment: The commentator said: *'Does this study prove that RP is better than WW for all patients with early prostate cancer? No. Should the results of this study be used to influence practice? Possibly, but because it reflects the choices of a bygone era, any extrapolation to contemporary practice must be tempered by caution.'* He also mentioned that radiotherapy and external beam brachytherapy has been shown to be effective and these were not a part of this design.

Paediatrics

26-057 An approach to 'failure to thrive'

Bergman P, Graham J. Aust Fam Physician. September 2005. Vol.34. No.9. p.725-9.
Reviewed by Dr Rachel Monk

Review: Failure to thrive is not an uncommon presentation in general practice. It is important to find the cause as if left it may result in multiple problems for the child in later years. This article offers an approach to diagnosis predominantly and a small section on treatment. It also uses a few case studies as illustrations.
Comment: I found this article extremely helpful. I hope you do too.

26-058 Child and adolescent growth disorders: an overview.

Simm PJ, Werther GA. Aust Fam Physician. September 2005. Vol.34. No.9. p.731-7.
Reviewed by Dr Rachel Monk

Review: Too tall, too short, when is it normal and when is it not? That is what this article aims to help GPs answer.
Comment: There is a good section of assessing growth and predicting adult height.

26-059 Developmental delay: identification and management.

Oberklaid F, Efron D. Aust Fam Physician. September 2005. Vol.34. No.9. p.739-42.
Reviewed by Dr Rachel Monk

Review: A case based article that focuses on assessing childhood development. A number of different tools are looked at.
Comment: It is difficult to find an ideal method of assessment in the context of a busy general practice. A practical approach is offered.

26-060 Weighty matters: an approach to childhood overweight in general practice.

McCallum Z, Gerner B. Aust Fam Physician. September 2005. Vol.34. No.9. p.745-8.
Reviewed by Dr Rachel Monk

Review: Childhood obesity is much more common than in the past and has implications for future health. This article offers some suggestions as to how we might tackle this in general practice.
Comment: Some of the suggestions I think will be very useful...looking forward to trying them out in my own practice.

26-061 Fever in children.

Pearce C, Curtis N. Aust Fam Physician. September 2005. Vol.34. No.9. p.769-71.
Reviewed by Dr Rachel Monk

Review: Is fever good or bad? What does it really mean? Do we have to

treat it? These are the questions this article looks at answering.
Comment: Have a read...it might change the way you practice...or it might not.

26-062 Approach to evaluation of sexual assault in children: Experience of a secondary-level regional pediatric sexual assault clinic.
Smith WG, Metcalfe M, Cormode EJ, et al. Can Fam Physician Med Fam Can. October 2005. Vol.51. p.1347-51.
Reviewed by Dr Mike Lyons
Review: A case scenario of alleged sexual abuse of a three-year-old girl is used to open discussion and then continue with the experiences of this secondary level sexual abuse clinic. Physical findings are usually few and non specific. Urgent referral from a GP is only indicated in cases of assault disclosure, symptoms of acute pain, bleeding, discharge or abnormal results on physical exam. Most cases can be referred non urgently.
Comment: Acknowledges that GPs may feel inadequately trained in this age of superspecialisation but states we play a crucial role in open discussion and preparation for referral.

Pharmacology

26-063 New bull's-eyes for drugs.
Kenakin T. Sci Am. October 2005. Vol.293. No.4. p.50-7.
Reviewed by Dr Ron Vautier
Review: The G-protein coupled receptors are a widespread and versatile group of cell-surface signal transducers. Many different molecules can interact with them to stimulate or inhibit them in some newly appreciated mechanisms.
Comment: Many existing drugs work through GPCRs, so this article is about the fundamentals of some very important pharmacology. It is very simply and clearly presented.

26-064 Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits.
Glass J, Lanctot KL, Herrmann N, et al. BMJ. 19 November 2005. Vol.331. No.7526. p.1169.
Reviewed by Dr Len Brake
Review: Convincing older people to change from their barbiturate sedative – often being taken every night for 10–20 years to the new nitrazepam which 'is non addictive' – was a hell of a job but, by the late 1970s, we had managed to convert almost all these patients to the benzodiazepines. Then the concept of 'dependency' became of concern – the more so if the patients were women and the doctors were men. This controversy triggered a rise in 'street value' of the benzodiazepines and one of the consequences is that this group of safe and cheap drugs are now on the 'controlled' list. The benzodiazepine receptor antagonist has achieved somewhat of a foothold as medication for sleep problems. There has been an effort to use the drowsiness side effect of the tricyclics as a sleep inducer. This study is interesting mostly as it shows that although sedative use improves sleep, the magnitude of the effect is very small.

Preventive Medicine and Screening

26-065 Screening for prostate cancer: Who and how often?
Schwartz K, Deschere B, Xu J. J Fam Pract. July 2005. Vol.54. No.7. p.586-96.
Reviewed by Dr Bruce Adlam
Review: This article reviews the latest information relevant to the controversy, offers 'talking points' for family physicians to use when discussing screening with patients, and lists websites that patients may find helpful when making a decision about prostate cancer screening. Useful all with strength of recommendation B: include: (1) Engage patients in shared decision making by discussing the benefits and risks of prostate cancer screening. Patients who review educational pamphlets before an office visit engage more fully in the decision-making process. (2) If performing prostate cancer screening, limit to men with greater than 10 years life expectancy. (3) Because the lead time of a diagnosis based on PSA screening is estimated to be five to seven years, PSA screening every other year is unlikely to cause a loss of sensitivity. (4) Men with tumors with a Gleason score less than five are the best candidates for 'watchful waiting', having a favorable 20-year survival.
Comment: Excellent comprehensive review

Primary Health Care

26-066 What do patients and the public want from primary care?
Coulter A. BMJ. 19 November 2005. Vol.331. No.7526. p.1199-201.
Reviewed by Dr Len Brake
Review: Patients care more about the quality of their everyday interactions with health professionals than about how the GP service is organised. Patients want GPs and GP nurses to be good communicators and be up to date with clinical knowledge. They also want professionals who are interested and sympathetic, involve them in decisions, give them sufficient time and attention and provide advice on health promotion and self care. They want extended clinic opening hours.

Comment: This UK study shows that most patients are willing to be seen by nurses and other primary care practitioners, as well as doctors, suggesting scope to encourage team work as a means of improving access. Continuity of care is valued by the majority, especially those with chronic diseases.

Psychiatry and Psychology

26-067 Emotional growth: helping children and families 'bounce back'

Noble T, McGrath H. Aust Fam Physician. September 2005. Vol.34. No.9. p.749-52.
Reviewed by Dr Rachel Monk

Review: Interesting approach to helping young people (and probably older people too) when faced with difficulties. Focus on optimism rather than pessimism. May have a role in reducing depression in our youth.

Comment: The bounce back acronym might be useful even in a 15min consultation.

Respiratory System

26-068 Antibiotic choice makes little difference in CAP.

J Fam Pract. June 2005. Vol.54. No.6. p.494.
Reviewed by Dr Bruce Adlam

Review: This careful meta analysis came up with some interesting findings comparing a beta-lactam antibiotic (amoxicillin, amoxicillin/clavulanate , or a cephalosporin) with an antibiotic active against the atypical pathogens M pneumoniae, Legionella species, and C pneumoniae (macrolides, fluoroquinolones, or ketolides) in the treatment of non-severe community acquired pneumonia. Neither macrolides, ketolides, or fluoroquinolones were superior to beta-lactam antibiotics. Also there was no difference between beta-lactams and the other drugs in patients who had M pneumoniae or C pneumoniae, although the numbers of patients in these subgroups were small, but antibiotics active against atypical pathogens were significantly better at producing clinical cures in the treatment of 75 patients with Legionella. (Original article reviewed see 26-069)

26-069 Effectiveness of beta lactam antibiotics compared with antibiotics active against atypical pathogens in non-server community pneumonia: meta-analysis.

Mills GD, Oehley MR, Arroll B. BMJ. 26 February 2005. Vol.330. No.7489. p.456-60.
Reviewed by Dr Bruce Adlam

Review: See 26-068.

26-070 10-minute consultation: Snoring.

Parker RJ, Hardinge M, Jeffries C. BMJ. 5 November 2005. Vol.331. No.7524. p.1063.
Reviewed by Dr Len Brake

Review: I routinely download these 10 minute consultation series, and a handy little series it is too, to be filed away to read during the quiet times over coffee. This treatise on 'snoring' is so devoid of 'things GPs can do' it is hardly worth the effort of filing. This is not the fault of the authors who have drawn the short straw in being allotted this topic.

Comment: Essentially: Too fat, too drunk, sew tennis ball in sock to back of pyjamas, refer if possible sleep apnoea. The end.

Screening

26-071 US Preventive Services Task Force: The gold standard of evidence-based prevention.

Campos-Outcalt D. J Fam Pract. June 2005. Vol.54. No.6. p.517-9.
Reviewed by Dr Bruce Adlam

Review: This article lists the USPSTF recommendations and rationale for screening made in 2004 and 2005. As important are the recommendations against various routine screening measures.

Comment: Good background for PHOs.

Sports and Sports Medicine

26-072 An evaluation of mouthguard requirements and dental injuries in New Zealand rugby union.

Quarrie KL, Gianotti SM, Chalmers DJ, et al. Br J Sports Med. September 2005. Vol.39. No.9. p.650-4.
Reviewed by Dr Chris Milne

Review: Since wearing mouthguards has been made compulsory in New Zealand rugby, there has been a 43% reduction in rugby related dental injury claims. For individuals, non-wearers of mouthguards had a relative risk of 4.6 times of making a dental injury claim.

Comment: It's nice to have proven what you would expect empirically – wearing a mouthguard does help preserve your teeth.

26-073 Supervised physiotherapy after arthroscopic partial menisectomy: is it effective?

Goodwin PC, Morrissey MC. Br J Sports Med. October 2005. Vol.39. No.10. p.692.
Reviewed by Dr Chris Milne

Review: This is a highly contentious topic. The authors reported in 2003 that a supervised physiotherapy programme after partial menisectomy was no more effective than written and verbal advice. They challenge others who believe their supervised programme offers superior results to; (a) describe it accurately, (b) subject it to formal study, and (c) publish their results.

Comment: My suspicion is that like many other therapies, it is rather patient-specific. The patients who have most to gain from a supervised programme are probably those who have poor understanding of basic instructions and lack the wherewithal to follow a simple home-based regime.

26-074 Characterising the individual performance responses to mild illness in international swimmers.

Pyne DB, Hopkins WG, Batterham AM, et al. Br J Sports Med. October 2005. Vol.39. No.10. p.752-6.
Reviewed by Dr Chris Milne

Review: This study, based at the Australian Institute of Sport, found that the average illness related change across all swimmers was trivial. However, male swimmers had a slower performance (averaging 0.5 seconds in a 200 metre race lasting approximately two minutes).
Comment: If you're the doctor, that's minimal, if you're the swimmer, that's important.

26-075 Epidemiology of injuries in English professional rugby union: part 1 match injuries.

Brooks JH, Fuller CW, Kemp SP, et al. Br J Sports Med. October 2005. Vol.39. No.10. p.757-66.
Reviewed by Dr Chris Milne
Review: Five hundred and forty-six professional rugby players at 12 English clubs were studied over two seasons. The overall injury incidence was 91 injuries per 100 player hours, and each injury resulted in an average of 18 days to recovery. On average, a club will have 18% of players unavailable for selection as a consequence of match injuries.
Comment: Rugby is a collision sport, best played by large mesomorphs. These figures bear out this conclusion. (see also 26-076).

26-076 Epidemiololgy of injuries in English professional rugby union: part 2 training injuries.

Brooks JH, Fuller CW, Kemp SP, et al. Br J Sports Med. October 2005. Vol.39. No.10. p.767-75.
Reviewed by Dr Chris Milne
Review: The overall training injury incidence was two per 100 player hours, and each injury resulted in an average of 24 days to recovery. On average, a club will have 5% of players unavailable for selection as a consequence of training injuries.
Comment: These figures are comparable with those for New Zealand professional players. (see also 26-075).

26-077 Muscle activity during the golf swing.

McHardy A, Pollard H. Br J Sports Med. November 2005. Vol.39. No.11. p.799-804.
Reviewed by Dr Chris Milne
Review: The golf swing is a complex movement of the whole body, relying on the co-ordinated sequence of muscle activation to produce a fluid and reproducible movement. This paper reviews the literature on golf swing related muscle activity, and includes all relevant EMG studies.
Comment: A worthwhile paper which draws together many complex ideas and presents these in a concise way. Probably required reading for all those analytical golfing doctors who want to reduce their handicap!

26-078 Identifying and managing shoulder pain in competitive swimmers: How to minimize training flaws and other risks.

O'Donnell CJ, Bowen J, Fossati J. Physician and Sportsmedicine. September 2005. Vol.33. No.9. p.27-35.
Reviewed by Dr Rob Campbell
Review: One-third of competitive swimmers have problems with shoulder pain. Overuse, laxity and strong anterior chest muscles often with a tight posterior capsule are some risk factors. Good technique, avoidance of stretching and specific strengthening are important and this paper describes this well.
Comment: This is an excellent summary of the swimmer's shoulder problems and has good descriptions of rehabilitation exercises with photos.

26-079 Evaluation and management of hip pain: the emerging role of hip arthroscopy.

Larson CM, Swaringen J, Morrison G. Physician and Sportsmedicine. October 2005. Vol.33. No.10. p.26-32.
Reviewed by Dr Rob Campbell
Review: This paper explores the conditions which may be successfully treated with arthroscopy. Labral tears and the uncommon ligamentum teres tears are described along with the assessments.
Comment: Labral tears are being diagnosed more frequently now in the patient with mechanical symptoms and surgery is usually indicated for continuing pain.

Therapeutics

26-080 What illnesses contraindicate immunization?

Plescia M, Leach L. J Fam Pract. July 2005. Vol.54. No.7. p.621-3.
Reviewed by Dr Bruce Adlam
Review: The Advisory Council on Immunization Practices (ACIP) in USA reports that the only contraindication for all vaccines is a history of severe allergic reaction to a previous vaccine or vaccine constituent (SOR: C), based predominantly on case series, case reports, and expert opinion). Vaccination is safe and efficacious in the following situations: during a mild illness (e.g. diarrhoea, otitis media or other mild upper respiratory infection whether or not the patient has a fever), during antimicrobial therapy, during the convalescent phase of an acute illness, when breastfeeding, and after mild to moderate reactions to a previous dose of vaccine. Live vaccines (varicella, MMR) should not be used for pregnant women or significantly immunocompromised patients.
Comment: Failure to vaccinate due to inappropriate contraindications, particularly mild illness, is a missed opportunity and significant contributor to under-immunisation.

26-081 Self management of oral anticoagulation: a randomised trial.

Fitzmaurice DA, Murray ET, McCahon D, et al. BMJ. 5 November 2005. Vol.331. No.7524. p.1057.
Reviewed by Dr Len Brake
Review: This study caught my eye as I am aware of the inordinate amount of time involved in uncoordinated management of warfarin therapy. Faxes arriving with random INR results late in the day, nurses'

attempts to get doctor to view and annotate dosage of warfarin then contacting the patients or their caregivers, etc. This has been helped to an extent by an every second Wednesday INR testing (or monthly in stable patients) and a protocol for the practice nurse to alter doses following an agreed formula. But still there could be room for a self help approach with access to the home INR finger prick machines now available.

Comment: This extensive enough trial was limited by the low percentage of patients (25%) who agreed to participate. I have a hunch that this could be a similar percentage to what could be attained in New Zealand. May not be worth it. Also the machines are quite costly.

26-082 Risk of adverse gastrointestinal outcomes in patients taking cyclo-oxygenase-2 inhibitors or conventional non-steroidal anti-inflamatory drugs: population based nested case-control analysis.

Hippisley-Cox J, Coupland C, Logan R. BMJ. 3 December 2005. Vol.331. No.7528. p.1310-6.

Reviewed by Dr Len Brake

Review: This is a large nested case control study measuring adverse GI events associated with COX2 inhibitors, NSAID and aspirin. NSAIDs are associated with serious gastrointestinal side effects. There was a marketing slant that the 'newer' cyclo-oxygenase-2 inhibitors would have a safer profile than the 'older' NSAIDs. This study disputes this, finding no evidence for enhanced safety. The use of ulcer healing drugs did reduce the risk of adverse GI outcomes with all groups of NSAIDs except diclofenac for which the increased risk remained significant.

Comment: What this study does not mention is the issue of the very very marginal, if any, benefits of the NSAIDs over paracetamol. The direct to patient advertising leniency in New Zealand may be a factor.

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Manuscripts

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

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Reports of research projects involving human subjects should include a statement indicating that the project has received ethical approval.

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

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Subscriptions

The journal is provided free to all members of the RNZCGP. Rates for others are $120 per year within New Zealand, $108 plus $42 postage outside New Zealand. The Royal New Zealand College of General Practitioners, P O Box 10440, Wellington, New Zealand.

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