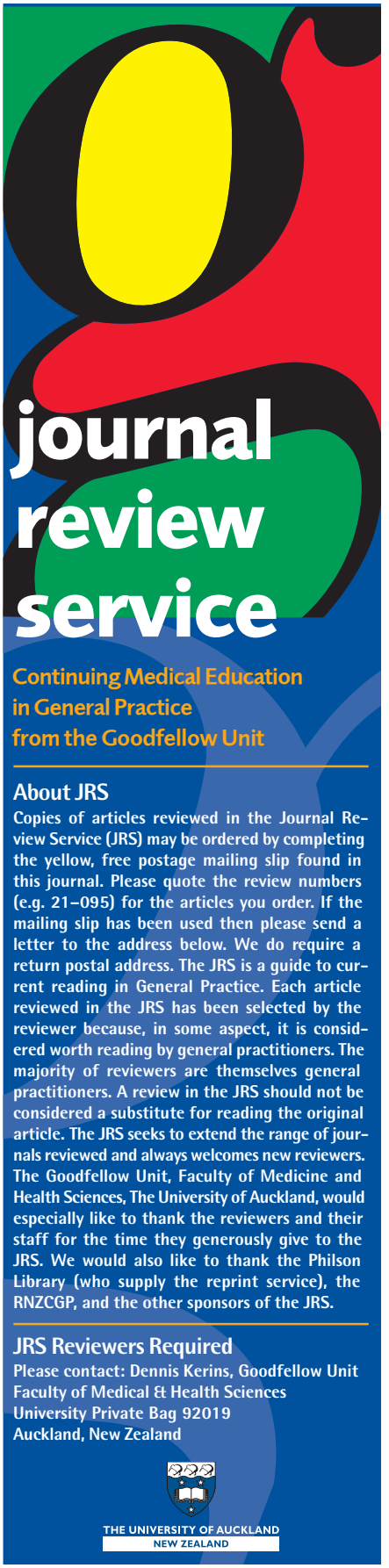


Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Br J Sports Med*
Can Fam Physician Med Fam Can*
CMAJ*
Intern Med J*
J Fam Pract*
JAMA*
Lancet*
N Engl J Med*
Neurology*
Palliative Med*
Pediatrics*
Prim Care*
Thorax*

*Journals indexed in Medline

Alcohol and Substance Abuse

27-001 Misuse of and dependence on opioids: Study of chronic pain patients

Kahan M, Srivastava A, Wilson L, et al. Can Fam Physician Med Fam Can. September 2006. Vol.52. p.1081-7.
Reviewed by Dr Mike Lyons

Review: These addiction clinic specialists outline the identification of opioid dependent patients in general practice and suggest a management plan. Tables include an opioid risk tool, behaviours suggesting opioid dependence, clinical features of pain patients without addiction versus addiction, urine testing for drugs and management of suspected opioid misuse. Management strategies include structured prescribing, treatment contracts, urine testing and when these fail, referral to a methadone programme.
Comment: Thought provoking article for these difficult patients.

Alternative Medicine

27-002 Complementary, alternative, proven, unproven

Thomson D. Intern Med J. October 2006. Vol.36. No.10. p.623-4.
Reviewed by Dr Helen Moriarty

Review: This brief editorial covers the topic of Complementary and Alternative Medicine (CAM) from the view point of definition. Definitions are problematic and terms are used interchangeably, where they can add to confusion. Alternate therapy should be just that: something used 'instead of" traditional treatment. Complementary therapy does not necessarily replace usual care, but can enhance it. Such therapies can also be classified as 'proven' or 'unproven'. The article makes the point that even 'unproven' treatments have benefit where the patient believes in them.
Comment: The paper makes a good case for patient-centred medicine.

Asthma

27-003 High-dose inhaled fluticasone does not replace oral prednisolone in children with mild to moderate acute asthma

Schuh S, Dick PT, Stephens D, et al. Pediatrics. August 2006. Vol.118. No.2. p.644-50.
Reviewed by Dr Jocelyn Tracey

Review: This is a randomised double blind control trial based in ED of 69 children five to 17 years with FEV1 50–79% of predicted. 2 mg fluticasone stat followed by 500 ug bd for five days was compared with five daily doses of prednisolone at 1mg/kg. At 4 hrs the prednisolone group

showed a 30% improvement, and the fluticasone group a 19% improvement. Relapse rates at 48 hours were 12.5% and 0% respectively.
Comment: Seems better to go for the prednisolone.

27-004 Asthma symptom burden: relationship to asthma severity and anxiety and depression symptoms

Richardson LP, Lozano P, Russo J, et al. Pediatrics. September 2006. Vol.118. No.3. p.1042-51.
Reviewed by Dr Jocelyn Tracey
Review: 767 youth aged 11–17 with asthma were interviewed and a strong association found between the presence of an anxiety or depressive disorder and increased asthma symptoms. The study was unable to determine whether the asthma caused the anxiety and depression or visa versa.
Comment: Assessing for anxiety and depression may be an important part of helping youth with asthma.

Cardiovascular System

27-005 Aggressive lowering of blood pressure

Kannel WB, Vasan RS. Lancet. 19-25 August 2006. Vol.368. No.9536. p.627-8.
Reviewed by Dr Tony Hanne
Review: Guidelines on the management of hypertension are moving to lower target levels. This comment by some of the Framingham researchers puts some of the arguments about the wisdom or otherwise of this approach into perspective. Lower systolic and diastolic pressures reduce cardiovascular risk in almost all circumstances. Higher systolic levels in the elderly used to be regarded as safer to avoid falls but evidence now refutes this. Diastolic pressures of 70 or less were thought to be part of a 'J' curve effect with increased risk but this now only seems to be so in those who have suffered a myocardial infarction in which there was a substantial drop of subsequent blood pressure.
Comment: The bottom line – lower blood pressure in nearly all patients, including the elderly is good.

27-006 Association of bodyweight with total mortality and with cardiovascular events in coronary artery disease: a systematic review of cohort studies

Romero-Corral A, Montori VM, Somers VK, et al. Lancet. 19-25 August 2006. Vol.368. No.9536. p.666-78.
Reviewed by Dr Tony Hanne
Review: Body Mass Index (BMI) has been the gold standard for measuring obesity and therefore presumed cardiovascular risk for many years. Could we have got it seriously wrong? This systematic review of the relationship of BMI to risk in those with established coronary artery disease produced some startling results. Those under BMI of 20 have an increased risk of death; those between 25 and 30 have a reduced risk; those between 30 and 35 have the same risk as patients with a BMI between 20 and 25. Only when the BMI is above 35 does the risk rise again.
Comment: The significance and limits of this study need careful thought. It was only for 3.8 years average. It was limited to those with established disease. It did not include other means of measuring visceral obesity such as waist/hip ratio. It did not include the longer-term risk associated with a higher rate of diabetes. See also comment 27-007.

27-007 Should we continue to use BMI as a cardiovascular risk factor?

Franzosi MG. Lancet. 19-25 August 2006. Vol.368. No.9536. p.624-5.
Reviewed by Dr Tony Hanne
Review: See 27-006.

27-008 Patients with acute myocardial infarction have an inaccurate understanding of their risk of a future cardiac event

Broadbent E, Petrie KJ, Ellis CJ, et al. Intern Med J. Ocotber 2006. Vol.36. No.10. p.643-7.
Reviewed by Dr Helen Moriarty
Review: A well written paper which demonstrates the huge discrepancy between medical and patient perception of risk. The discussion raises interesting issues for consideration: that patients form perceptions early and it is difficult to subsequently change those; that doctors may be poor at communicating risk to patients; and how much patient mood influences perception of illness.
Comment: Food for thought, but also a good example of a well, designed study.

27-009 Oral magnesium therapy, exercise heart rate, exercise tolerance, and myocardial function in coronary artery disease patients

Pokan R, Hofmann P, von Duvillard SP, et al. Br J Sports Med. 1 September 2006. Vol.40. No.9. p.773-8.
Reviewed by Dr Chris Milne

Review: Magnesium is an essential element, and epidemiologic evidence suggests that it plays an important role in regulatory blood pressure. These authors found that magnesium supplementation improved resting myocardial function and exercise performance.
Comment: This is useful to know. The next time one of your concerned cardiac patients asks you about this, you can feel better informed, and reassure them that there is some published evidence for benefit from magnesium.

27–010 Erectile dysfunction is a signal of risk for cardiovascular disease: a primary care view.

Sadovsky R, Miner M. Prim Care. December 2005. Vol.32. No.4. p.977-93.
Reviewed by Dr M Hewitt
Review: Although erectile dysfunction is a multi-system disorder the most likely predisposing factor is of vascular aetiology. In this regard, it can be considered as a reliable indicator of otherwise undiagnosed cardiovascular disease.
Comment: Often it is the small arteries which are first affected by the disease process.

27–011 Family history of coronary heart disease: evidence-based applications

Crouch MA, Gramling R. Prim Care. December 2005. Vol.32. No.4. p.995-1010.
Reviewed by Dr M Hewitt
Review: A comprehensive look at the evidence and epidemiology of predictive factors involving hereditary and the effect of family environment on coronary heart disease outcomes.
Comment: An unhealthy family environment coupled with hereditary risk factors such as lipid profile, makes for poor outcomes.

27–012 Hypertension

Campbell-Scherer DL, Green LA. Prim Care. December 2005. Vol.32. No.4. p.1011-1026.
Reviewed by Dr M Hewitt
Review: Evidence is overwhelming for the screening, prevention and treatment of hypertension in the aetiology of overall mortality from cardiovascular and arteriovascular disease.

27–013 Hyperlipidemia

Eaton CB. Prim Care. December 2005. Vol.32. No.4. p.1027-55.
Reviewed by Dr M Hewitt
Review: A neat, concise review of the current mode understanding and best practice in the management and treatment of lipid disorders and their adverse consequences.

27–014 Community interventions for cardiovascular disease

Parker DR, Assaf AR. Prim Care. December 2005. Vol.32. No.4. p.865-81.
Reviewed by Dr M Hewitt
Review: The authors look at various community-based programmes for prevention of cardiovascular disease and the reasons for success or lack of it with regard to intervention outcomes.
Comment: Our own PREDICT compares favourably with those analysed by the authors.

27–015 Office systems for heart disease prevention

Underbakke G, McBride PE. Prim Care. December 2005. Vol.32. No.4. p.883-900.
Reviewed by Dr M Hewitt
Review: Use of the practice management system for screening for risk factors is discussed. The effectiveness depends on implementations of interventions based on the information acquired.
Comment: Requires good history taking and data entry input. Retrieval of the information entered should present no problem to most practice management systems. It is the implementation that makes the difference.

27–016 The electrocardiogram in the primary care office

Patel PM, Wu W-C. Prim Care. December 2005. Vol.32. No.4. p.901-30.
Reviewed by Dr M Hewitt
Review: An update of how to analyse and interpret ECG taken in the office setting.
Comment: More sophisticated devices come with software which does the interpretation. However, this does not negate the necessity for the doctor to provide the most appropriate interpretation for the clinical circumstances.

27–017 Diagnosis and screening of coronary artery disease

Anthony D. Prim Care. December 2005. Vol.32. No.4. p.931-46.
Reviewed by Dr M Hewitt
Review: This article summarises the end point of screening in the form of stress – ECG and cardiac MRI scanning. These are a prelude to treatment for the end-stage of the process.
Comment: In NZ we begin screening earlier, at the primary care interface and with low-tech methods.

27–018 Lifestyle and coronary heart disease prevention

Pinto BM, Rabin C, Farrell N. Prim Care. December 2005. Vol.32. No.4. p.947-61.
Reviewed by Dr M Hewitt
Review: Same old, same old. The article focuses on smoking, diet and exercise as the interventions shown on evidence-based research to make a meaningful difference. The literature supporting these interventions is referred to and cited.
Comment: In NZ, recent analysis has now got cancer as the leading cause of death, displacing cardiovascular disease from the number 1 spot. This is a tribute to the 'success of the package', of screening, intervention and treatment.

27–019 Traditional and emerging risk factors for cardiovascular disease

Eaton CB. Prim Care. December 2005. Vol.32. No.4. p.963-76.
Reviewed by Dr M Hewitt
Review: The authors discuss the familiar and recognised risk factors for preventing cardiovascular disease as well as looking at genetic causes for the disease.
Comment: Traditional risk factors such as lifestyle, lipids and inherit-

ance make for strong predictive outcomes. A good case in question is the stronger predictive value of family history and LDL cholesterol levels for CVD.

27-020 Management of coronary heart disease: stable angina, acute coronary syndrome, myocardial infarction.

Mehta SB, Wu W-C. Prim Care. December 2005. Vol.32. No.4. p.1057-81.
Reviewed by Dr M Hewitt
Review: This article provides an insight for the primary care physician as to the updated outpatient and inpatient management of these life-threatening conditions of coronary heart disease.

27-021 Does stopping a statin increase the short-term risk of a cardiovascular event?

Crawford P, Hitchcock K. J Fam Pract. June 2006. Vol.55. No.6. p.533-4.
Reviewed by Dr Bruce Adlam
Review: Evidence-based answer:- When statins are stopped by asymptomatic patients, there appears to be no increased risk of cardiovascular events (strength of recommendation [SOR]: B,). However, for patients who have recently experienced a cardiovascular event, discontinuation of statins increases the risk of further events (heart failure, arrhythmia, shock), and death (SOR: B,). In patients who were admitted for chest pain and had their statin withdrawn, this effect was seen in the first week and was independent of cholesterol levels and measures of severity of illness.
Comment: The benefits of statin therapy appear to extend beyond the realm of their cholesterol-lowering properties. Other studies have shown benefits are seen quickly after initiation of therapy. Studies in patients with stroke and those with only risk factors for cardiovascular disease show that platelet activity is increased, and tissue plasminogen activator levels are decreased when statins are discontinued. This results in a relatively hypercoagulable state.

27-022 How accurate is the use of ECGs in the diagnosis of myocardial infarct?

Ginn PH, Jamieson B. J Fam Pract. June 2006. Vol.55. No.6. p.539-40.
Reviewed by Dr Bruce Adlam
Review: Evidence based answer: The ECG is a fairly accurate test in the diagnosis of MI noting there are more sensitive technologies, such as cardiac biomarkers in the evaluation and detection of MI. (SOR: A) The sensitivity of ECG for detection of MI is directly related to what is defined as positive findings on the ECG for MI. The single most specific ECG finding is the presence of new ST segment elevation of at least 1mm. (SOR: A) Other findings such as the development of new pathologic Q waves and ST depression can also be valuable in making the diagnosis.

Cerebrovascular System

27-023 Effectiveness of collaborative care for older adults with Alzheimer disease in primary care: A randomized controlled trial

Callahan CM, Boustani MA, Unverzagt FW. JAMA. 10 May 2006. Vol.295. No.18. p.2148-57.
Reviewed by Dr Raina Elley
Review: A primary health care coordinated care pathway based on American guidelines for care of people with Alzheimers or related dementias is more effective than usual care. Intervention patients received better quality care, had fewer psychological and behavioural symptoms, and there was better coping and mental health of caregivers, but no difference in cognition compared with the 'usual care' group. The intervention was coordinated between the GP and geriatric nurse.
Comment: This is a valuable article for those interested in the evidence behind Alzheimer and Dementia guidelines. The paper contains a box with the relevant recommendations that were followed by the intervention pathway. The trial design was rigorous, using a cluster RCT of 74 family physicians randomised to intervention or control (153 patients), and with blinded assessment, so the evidence is strong.

27-024 Access to stroke care units in Australian public hospitals: facts and temporal progress

Cadilhac DA, Lalor EE, Pearce DC, et al. Intern Med J. November 2006. Vol.36. No.11. p.700-4.
Reviewed by Dr Helen Moriarty
Review: Evidence suggests that outcomes from acute stroke can be improved by prompt care in a stroke unit. The authors wrote to hospitals to survey availability and access to stroke units in Australia. Australia is poorly served in comparison to Sweden and other countries, by public hospital provision of stroke care units. New Zealand will be even less well serviced.
Comment: Stroke care unit was defined as having dedicated beds localised to a multi-disciplinary team, with a clinical leader. Access to CT, on-site neurosurgery and high dependency unit identified category A and D units – setting a standard NZ could not hope to emulate in most centres.

Communicable Diseases, Infections and Parasites

27-025 An effective nonchemical treatment for head lice: a lot of hot air

Goates BM, Atkin JS, Wilding KG, et al. Pediatrics. November 2006. Vol.118. No.5. p.1962-70.
Reviewed by Dr Jocelyn Tracey
Review: Six different ways to kill head lice with heat, including your standard hair blow dryer!
Comment: A relatively effective alternative – precise instructions are in the article.

Dermatology

27-026 Expert committee recommendations for acne management

Zaenglein AL, Thiboutot DM. Pediatrics. September 2006. Vol.118. No.3. p.1188-99.
Reviewed by Dr Jocelyn Tracey
Review: An update on treatment for acne. Topical retinoids are promoted as the mainstay of treatment, with local oral antibiotics and benzoyl peroxide added in as necessary. Oral antibiotics are next line, should not be used as monotherapy or for long periods of time.
Comment: A useful update.

Diabetes

27-027 Effect of rosiglitazone on the frequency of diabetes in patients with impaired glucose tolerance or impaired fasting glucose: a randomised controlled trial

The DREAM Trial Investigators. Lancet. 23-29 September 2006. Vol.368. No.9541. p.1096-105.
Reviewed by Dr Tony Hanne
Review: Over 5000 patients who were at risk of developing type 2 diabetes were randomised to treatment with rosiglitazone 8mg daily or placebo, for three years. Both groups were given the same lifestyle advice. A substantially greater proportion of the treated group became normoglycaemic by the end of three years.
Comment: This Canadian led 'Dream Team' has produced a very solid case for being proactive with impaired glucose patients. Thirty per cent of the effect was from lifestyle advice and an extra 20% from glitazone. Both are obviously worthwhile.

27-028 Diabetic peripheral neuropathy: How reliable is a homemade 1-g monofilament for screening?

Bourcier ME , Ullal J, Parson HK, et al. J Fam Pract. June 2006. Vol.55. No.6. p.505-8.
Reviewed by Dr Bruce Adlam
Review: Use fishing line cut to different lengths (4 cm = 10-g; 8 cm = 1-g) as substitutes for monofilaments to assist in the diagnosis of diabetic neuropathy. This test is highly specific for neuropathy; using longer lengths of line increases sensitivity.
Comment: Slightly OTT study to validate fishing line for this purpose.

Education

27-029 Continuing professional development for rural physicians: an oxymoron or just non-existent?

McLean R. Intern Med J. October 2006. Vol.36. No.10. p.661-4.
Reviewed by Dr Helen Moriarty
Review: Australia faces issues of remote practitioners and challenges for their CPD just as NZ does. This paper discusses some hopeful directions.
Comment: I get the feeling that L'll ol' NZ is already several steps ahead of Oz.

27-030 Time for a medical educational change in time

Gorman D, Scott J. Intern Med J. November 2006. Vol.36. No.11. p.687-9.
Reviewed by Dr Helen Moriarty
Review: Two Auckland physicians argue that post-graduate training for specialties should be competence-driven, not time dependent. They cite the RACP Faculty of Occupational Medicine who now pass trainees when they show they can meet stated competencies. Tongue in cheek, but advisedly so, they refer to Part 1 (Primex) exams as a 'raffle'. They also dispute the wisdom of exposing undergraduate to more general practice, suggesting that an increase in exposure may be 'negatively perceived'.
Comment: Ok guys, lets get writing and counter some of these comments!

Family Practice

27-031 A practical 3-step model for managing treatment refusal

Bekelman DB, Carrese JA. J Fam Pract. May 2006. Vol.55. No.5. p.403-7.
Reviewed by Dr Bruce Adlam
Review: The question is not 'Is there decisional incapacity or dangerousness?' but 'What degree of either is present?'. This approach to treatment refusal is consistent and involves clear standards and processes for evaluation, regardless of setting, problem, type of patient, or practitioner. It facilitates respect for persons, equal treatment independent of diagnosis, and appropriate involvement of surrogate decision-makers and the courts. Practice recommendations: (a) The process for evaluating treatment refusal should be consistent regardless of setting, problem (i.e. medical or psychiatric), type of patient, or practitioner: (b) Assess decisional capacity, psychiatric dangerousness, and medical risk in all cases of treatment refusal while addressing potential causes of treatment refusal; (c) Based on these assessments, choose between: i) respecting the treatment refusal, ii) obtaining a surrogate, or iii) mandating hospitalisation and possibly treatment.
Comment: The model uses two by two tables to assist in the decision making but in reality you would not be able to use these at the time. They might be useful for checking your consistency before or after the event.

Gastroenterology

27-032 Irritable bowel syndrome

Talley NJ. Intern Med J. November 2006. Vol.36. No.11. p.724-8.
Reviewed by Dr Helen Moriarty
Review: A review article which looks at the positive IBS criteria (Rome criteria) – rather than as diagnosis of exclusion. Gut hormones are dysregulated and bowel flora often disturbed. This makes IBS a 'real' condition rather than a psychogenic one. Genetics of IBS remains unclear. Traditional and novel serotonin antagonists have a role in management, as do non-absorbable antibiotics.
Comment: A useful paper to discuss with patients with IBS.

27-033 The spectrum of valproic acid-associated pancreatitis

Werlin SL, Fish DL. Pediatrics. October 2006. Vol.118. No.4. p.1660-3.
Reviewed by Dr Jocelyn Tracey
Review: A review of pancreatitis as a side effect of valproic acid. Serum lipase was a more sensitive investigation than serum amylase.
Comment: Something to remember when children (or adults) on valproic acid present with abdominal pain.

Geriatrics

27-034 Daily activity energy expenditure and mortality among older adults

Manini TM, Everhart JE, Patel KV, et al. JAMA. 12 July 2006. Vol.296. No.2. p.171-9.
Reviewed by Dr Raina Elley
Review: Exercise gained in everyday activities is associated with a lower risk of mortality in older people (over 70 years). Energy expenditure was measured by doubly labelled water in 302 70–79-year-olds who were then followed for eight years. Those with the greatest energy expenditure had significantly lower mortality rates (e.g. 12% in highest tertile vs 25% in lowest tertile) even after adjusting for self-rated health, education, health conditions, and smoking. These older people with higher energy expenditure were no more likely to do high intensity exercise, walk for exercise or do other walking compared with those with lower energy expenditure, according to self-report. But they were more likely to work for pay and climb stairs.
Comment: Expending energy through any daily activity (not necessarily dedicated 'exercise' or for sustained periods) may be protective in older age. The lack of correlation between walking or vigorous exercise and energy expenditure was interesting and may reflect at least in part the large potential recall bias in what we report we have done. The Mouth-brain gap means we underestimate what we eat and the foot-brain gap means we overestimate what activity we do. See also editorial 27-035.

27-035 Objectively measured physical activity and mortality in older adults

Blair SN, Haskell WL. JAMA. 12 July 2006. Vol.296. No.2. p.216-8.
Reviewed by Dr Raina Elley
Review: See 27-034.

Gynaecology

27-036 Nonhormonal therapies for menopausal hot flashes: systematic review and meta-analysis

Nelson HD, Vesco KK, Haney E, et al. JAMA. 3 May 2006. Vol.295. No.17. p.2057-71.
Reviewed by Dr Raina Elley
Review: SSRIs (or serotonin noradrenaline reuptake inhibitors [SNRIs]), clonidine and gabapentin were all effective in reducing the frequency of hot flushes, the most common menopausal symptom, according to a meta-analysis of trials. The meta-analysis also found that red clover isoflavone extracts were not effective and results were mixed for soy isoflavone extracts. There are few trials of other alternative therapies.
Comment: With hormonal therapies being less popular for menopausal symptoms, other alternatives are needed. Although some alternatives have been found to be effective, none were as effective as oestrogen at reducing the frequency of hot flushes. There are actually few (good quality) trials of alternatives. See also editorial 27-037.

27-037 Alternatives to estrogen for treatment of hot flashes: Are they effective and safe?

Tice JA, Grady D. JAMA. 3 May 2006. Vol.295. No.17. p.2076-8.
Reviewed by Dr Raina Elley
Review: See 27-036.

27-038 Ectopic pregnancy: expectant management or immediate surgery?

Ramakrishnan K, Scheid DC. J Fam Pract. June 2006. Vol.55. No.6. p.517-22.
Reviewed by Dr Bruce Adlam
Review: a) Surgery is preferred for ruptured ectopic pregnancy. Surgery is also indicated for patients with evidence of haemodynamic instability, anaemia, pain for longer than 24 hours, ß-hCG levels greater than 5000mIU/mL, or with a gestational sac that measures more than 3.5 to 4cm on ultrasound. b) Expectant management may be offered to asymptomatic patients with small adnexal masses (=3cm) lower beta-human chorionic gonadotropin (ß-hCG) levels (<1000 mIU/mL), evidence of spontaneous resolution (e.g. falling ß-hCG levels) who are willing to accept the risk of tubal rupture (A). c) Systemic methotrexate administration resolves ectopic pregnancy in 87% to 95% of cases, maintains tubal patency in 75% to 81%, and results in subsequent successful pregnancy in about 58% to 61% of patients.
Comment: Management strategies for patients with ectopic pregnancy have obviously evolved rapidly and this article is well worth reading.

Law and Medicine

27-039 Accountability sought by patients following adverse events from medical care: the New Zealand experience

Bismark M, Dauer E, Paterson R, et al. CMAJ. 10 October 2006. Vol.175. No.8. p.889-94.
Reviewed by Dr Jim Vause

Review: An interesting comparison of compensation claims to ACC against complaints to the H&DC in 1998. The researchers dredged through the files of both groups looking for the type of accountability complainants were seeking. Financial recompense was an important factor identified with ACC claimants, obviously, being to the fore. However, especially in H&DC cases, there were a number of other reasons behind complaints, with a desire to prevent it 'happening again' being very common.

Comment: This is interesting reading if somewhat predictable. We are lucky in many ways to not have financial recompense as a driver for complaints as occurs in many other nations. It is also good to read this and see why the Health and Disability Commissioner is realigning his role in using complaints for quality improvement. (see also commentary 27-040).

27-040 Monetary and nonmonetary accountability following adverse medical events: options for Canadian patients

Gray JE, Beilby W. CMAJ. 10 October 2006. Vol.175. No.8. p.903.
Reviewed by Dr Jim Vause

Review: See 27-039.

Musculoskeletal System

27-041 Single leg balance test to identify risk of ankle sprains

Trojian TH, McKeag DB. Br J Sports Med. 1 July 2006. Vol.40. No.7. p.610-3.
Reviewed by Dr Chris Milne

Review: Ankle sprains are one of the commonest injures. These authors describe use of this simple test. The subject stands on one leg in bare feet, with the other leg bent. Then, the eyes are closed for 10 seconds. The subject reports any sense of imbalance, and the observer checks if the subject's legs touched each other, or the opposite foot touched the ground.

Comment: Not surprisingly, a positive test predicted those people who were at highest risk of ankle sprains. If you're looking for a rational basis on which to advise proprioception exercises, and possibly prophylactic ankle taping this test could be it.

27-042 Prevalence of flat foot in preschool-aged children

Pfeiffer M, Kotz R, Ledl T, et al. Pediatrics. August 2006. Vol.118. No.2. p.634-9.
Reviewed by Dr Jocelyn Tracey

Review: 44% of three to six-year-old children have flexible flat feet, whereas less than 1% of children have pathological flat feet that require treatment. The article explains how to differentiate between pathological and flexible flat feet. Overweight children are more likely to have flat feet. 10% of children were using arch supports.

Comment: Explaining the contents of this article to concerned parents could save them from purchasing unnecessary arch supports.

27-043 'Underuse' as a cause for musculoskeletal injuries: is it time that we started reframing our message?

Stovitz SD, Johnson RJ. Br J Sports Med. 1 September 2006. Vol.40. No.9. p.738-9.
Reviewed by Dr Chris Milne

Review: These authors challenge the current view of overuse injuries. They state that instead of overuse, many such injuries are the result of previous under use, followed by movement of the body in an unfamiliar manner. In support of their argument, the authors quote recent research on back pain that advocates activity rather than rest.

Comment: A useful article, with which I partly agree. For those apophyseal injuries of adolescence (e.g. Sever's Osgood-Schlatters) I'd still recommend rest in the acute phase, followed by graded activity.

27-044 Ultrasound guided electrocoagulation in patients with chronic non-insertional Achilles tendinopathy: a pilot study

Boesen MI, Torp-Pedersen S, Koenig MJ, et al. Br J Sports Med. 1 September 2006. Vol.40. No.9. p.761-6.
Reviewed by Dr Chris Milne

Review: In recent years, midsection Achilles tendon pain has been found to be related to tendinopathy, with minimal evidence of inflammation. Therefore the previously used term of tendonitis has been superceded. Most patients improve with a programme of progressive concentric then eccentric exercises. For the few that do not, sclerosant injections have shown promise.

Comment: These injections should be reserved for those people who have not responded to at least three months of progressive eccentric exercises, and have new vessels demonstrated on colour Doppler ultrasound. They are available at a few selected centres in New Zealand.

Neurology

27-045 Cerebral palsy in a term population: Risk factors and neuroimaging findings

Wu YW, Croen LA, Shah SJ, et al. Pediatrics. August 2006. Vol.118. No.2. p.690-7.
Reviewed by Dr Jocelyn Tracey

Review: This study reviewed 377 infants with cerebral palsy, both in terms of risk factors, and CT or MRI scan evidence. Maternal age >35, black race and IUGR were all general risk factors for cerebral palsy. However different neuroimaging findings were also associated with other risk factors, such as night time delivery being associated with generalised brain atrophy type.

Comment: An interesting exploration of the heterogeneity of this condition.

Obstetrics

27-046 How can you prevent migraines during pregnancy?

Conner SJ, Sullo E. J Fam Pract. May 2006. Vol.55. No.5. p.429-30, 32.
Reviewed by Dr Bruce Adlam

Review: Evidence-based answer: No randomised controlled trials (RCT) have addressed pharmacologic prophylaxis of migraine for pregnant women. Two studies suggest that nonpharmacologic therapies (combinations of skin warming, relaxation, biofeedback, and physical therapy) not only relieved acute pain, but also decreased the frequency of headaches (strength of recommendation (SOR: B). The article includes a pregnancy risk category of some prophylactic drugs for migraine, however, in all, risk to humans has not been ruled out or there is positive evidence of risk to humans from human or animal studies.

Orthopaedics

27-047 Splint equal to cast for wrist buckle fracture in children

J Fam Pract. June 2006. Vol.55. No.6. p.476.
Reviewed by Dr Bruce Adlam
Review: In this RCT of 87 children between the ages of six and 15 years, a splint instead of a plaster cast improved functioning and provided similar pain relief with a buckle fracture. Refracture did not occur in either group. (Level of evidence [LOE]=1b). (Original article reviewed: Pediatrics 2006; 117:691-697)
Comment: Improvements with a splint include less difficulty bathing, writing, and grooming.

Paediatrics

27-048 Guideline: Hip dysplasia screening has insufficient evidence

J Fam Pract. June 2005. Vol.55. No.6. p.484.
Reviewed by Dr Bruce Adlam
Review: Routine screening of newborns using the Barlow and Ortolani tests may identify hip dysplasia early, although most of these cases will resolve spontaneously without intervention. The evidence of benefit of either surgical or nonsurgical interventions for hip dysplasia is poor. (LOE=4) (Original article reviewed: Pediatrics 2006; 117:898- 902)
Comment: Difficult to believe there are no adequate studies evaluating the role of screening or surgery. Dysplasia of the hip is estimated to occur in 1.5 to 20 children per 1000 births. Self-limiting hip instability is a common finding, and 90% of unstable hips will resolve without treatment between six weeks and six months spontaneously. Boils down to – is it a click or a clunk and even then most surgery that is performed is not as a result of findings found on screening.

27-049 Antidepressant drugs increase suicide risk in children

J Fam Pract. June 2006. Vol.55. No.6. p.488.
Reviewed by Dr Bruce Adlam
Review: This government funded meta-analysis comprising 4582 patients suggests the use of antidepressant medications in children is associated with an increased risk of suicidal ideation and suicide-related behaviours. It is uncertain what overall effect antidepressant medications have on the morbidity and mortality of treated children. Close monitoring of patients using these medications regarding the risk of suicidality is recommended. (LOE=1a-) Studied drugs included fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox), citalopram (Celexa), bupropion (Wellbutrin), venlafaxine (Effexor), nefazodone, and mirtazapine (Remeron). Sixteen trials studied patients with major depressive disorder, and the remaining eight studied obsessive-compulsive disorder, generalised anxiety disorder, attention-deficit/hyperactivity disorder, and social anxiety disorder. The selection process resulted in 130 unique patients with a suicidal-related event. The overall relative risk increase for suicidality for selective serotonin re-uptake inhibitors in depression trials was 1.66 (95% confidence interval [CI], 1.02-2.68; number needed to harm [NNH]=54, 95% CI, 21-1786) and for all drugs across all indications was 1.95 (95% CI, 1.28-2.98; NNH=38, 95% CI, 18-128). Venlafaxine was the only individual drug with a statistically significant increased risk of suicidality. There were no suicidal related events reported for nefazodone and bupropion. (Original article reviewed: Arch Gen Psychiatry 2006; 63:332-339)

27-050 Matters of spirituality at the end of life in the pediatric intensive care unit

Robinson MR, Thiel MM, Backus MM, et al.
Pediatrics. September 2006. Vol.118. No.3. p.719-29.
Reviewed by Dr Jocelyn Tracey
Review: Spiritual/religious themes were included in the responses of 73% (41 of 56) of parents to questions about what had been most helpful to them when faced with the death of their child. These related to prayer, faith, care from clergy, and belief in the transcendent quality of the parent-child relationship that endures beyond death.
Comment: A reminder to consider and be accepting of the spiritual concerns of patients when facing end of life issues.

27-051 Changing epidemiology of life-threatening upper airway infections: the reemergence of bacterial tracheitis

Hopkins A, Lahiri T, Salerno R, et al. Pediatrics. October 2006. Vol.118. No.4. p.1418-21.
Reviewed by Dr Jocelyn Tracey
Review: The increasing incidence of bacterial tracheitis is highlighted, with this now being a more common cause of respiratory failure in children in the US than viral croup and epiglottitis. First symptoms are similar to an URTI, but then high fever, respiratory distress and toxic appearance develop.
Comment: Another possibility to be aware of when children become toxic.

27-052 A systematic review for the effects of television viewing by infants and preschoolers

Thakkar RR, Garrison MM, Christakis DA. Pediatrics. November 2006. Vol.118. No.5. p.2025-31.
Reviewed by Dr Jocelyn Tracey
Review: The studies included in the review focused on the content of TV rather than length of time watched. There were pluses in terms of educational programmes increasing knowledge and some evidence that cartoon watching decreases a child's attention span.
Comment: Still not a lot of hard evidence.

Pain Management

27-053 Opioids for managing chronic non-malignant pain: Safe and effective prescribing

Kahan M, Srivastava A, Wilson L, et al. Can Fam Physician Med Fam Can. September 2006. Vol.52. p.1091-6.
Reviewed by Dr Mike Lyons
Review: These addiction clinic specialists background the indications and side effects of opioids in different types of chronic pain. Suggest treatment agreements, follow up documentation and outlines choice of opioid. Dose titration and switching to controlled release preparations are covered. Most patients' pain is controlled by doses less than 300 mgs morphine daily.
Comment: Helpful reminder.

Palliative Treatment

27-054 The use of benzodiazepines in palliative care

Henderson M, MacGregor E, Sykes N, et al. Palliative Medicine. July 2006. Vol.20. No.4. p.407-12.
Reviewed by Dr Peter Woolford
Review: This was a retrospective case note review of 100 consecutive patients at St Christopher's Hospice in London. 58% received benzodiazepines, a higher figure than other palliative populations. Most use was in the last three weeks of life, with a larger number using parenteral route. In 70–80% the medication was effective for the indication.
Comment: A retrospective study in a specific population, but nevertheless an indication of the usefulness and effectiveness of benzodiazepines particularly one presumes in the late symptoms of agitation or restlessness.

27-055 Who receives specialist palliative care in Western Australia – and who misses out

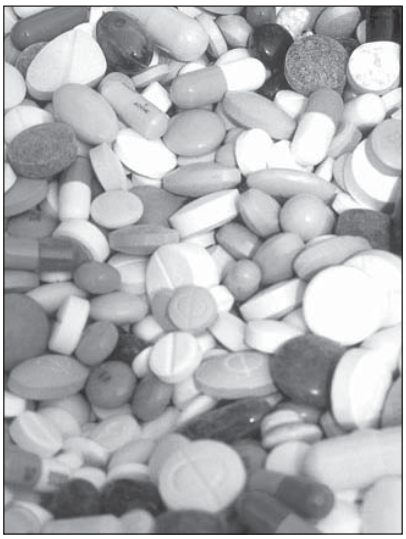
Rosenwax LK, McNamara BA. Palliative Med. July 2006. Vol.20. No.4. p.439-45.
Reviewed by Dr Peter Woolford
Review: This is another retrospective register analysis, reviewing all 27 971 deaths in Western Australia over a 2½ year period. Two-thirds (68%) of cancer patients received specialist palliative care (SPC) yet only 10% of non cancer terminally ill. The single, widowed, those older than 85 years and those not living in a major city were less likely to access SPC.
Comment: The title really begs the question. Do all dying patients actually need specialist palliative care. If not all patients with diabetes or heart disease or asthma access specialist services, then should the same apply to dying patients.

27-056 Does persistent involvement by the GP improve palliative care at home for end-stage cancer patients?

Aabom B, Kragstrup J, Vondeling H, et al. Palliative Med. September 2006. Vol.20. No.5. p.507-12.
Reviewed by Dr Peter Woolford
Review: Denmark is a small country with good quality health registers. This paper uses register-based data to analyse the relationship between the number of GP visits and whether the patient died in hospital. There was a clear relationship that the more GP visits a patient had the less likely they were to die in hospital. This relationship was also dose dependent.
Comment: Interpreting registers is a crude method of obtaining data, but does allow for much larger populations to be analysed. This is helpful population data and does tie in with smaller prospective studies.

27-057 The International Association for Hospice and Palliative Care List of Essential Medicines for palliative care

de Lima L. Palliative Med. November 2006. Vol.20. No.7. p.647-51.
Reviewed by Dr Peter Woolford
Review: An international team looked at the 17 most common symptoms in palliative care (from pain to hiccups to terminal restlessness to sweating), and then reached consensus on the best medications, in terms of efficacy and safety, for treatment of these symptoms. A final list of 32 was formulated related to the medications indicated.



Comment: A concise paper and the list speaks for itself. A good reminder of the pharmacological interventions, without being too much information.

27-058 Spiritual issues in palliative care consultations in the Netherlands

Kuin A, Deliens L. Palliative Med. October 2006. Vol.20. No.6. p.585-92.
Reviewed by Dr Peter Woolford

Review: The authors defined spirituality as *'the idea that human beings need to seek and find a meaning beyond their current suffering which allows them to make sense of that situation.' 'It can therefore be described as the search for existential meaning within a given life experience.'* This study found that spiritual issues were not commonly discussed by the specialist palliative care teams. Spiritual issues such as acceptance of illness, meaning of death, to be of value for others, to be engaged usefully, loss of confidence in God or religion were discussed in 437 of 4109 consultations.

Comment: In NZ I suspect GPs visiting patients' homes would discuss these issues commonly.

27-059 Heart failure and palliative care services working in partnership: report of a new model of care

Daley A, Matthews C, Williams A. Palliative Med. October 2006. Vol.20. No.6. p.593-601.
Reviewed by Dr Peter Woolford

Review: This paper describes a collaboration between community heart failure specialist nurses and palliative care services in Bradford, England.

Comment: It is becoming more widely understood that non-malignant terminal illness also carries a palliative care demand, needing similar skilled multidisciplinary team input to that provided for cancer sufferers. This paper describes one model of helping patients with end stage heart disease.

27-060 The management of anorexia by patients with advanced cancer: a critical review of the literature

Shragge JE, Wismer WV, Olson KL. Palliative Med. October 2006. Vol.20. No.6. p.623-9.
Reviewed by Dr Peter Woolford

Review: The authors reviewed available literature (52 studies) regarding anorexia in dying patients. Appetite loss is pretty well universal. However, food provision, acceptance and enjoyment is a representation of effective caregiving and anorexia interferes with the provision of these rewards, sometimes leading to problems in family relationships.

Comment: It is not yet clear if improved/high nutritional states have any effect on improving outcomes for cancer patients but some families and patients base their contribution to 'fighting the cancer' on nutrition and clearly there can be a discordance between patient and family. This is a good review.

Pharmacology

27-061 Risk of ischemic complications related to the intensity of triptan and ergotamine use

Wammes-van der Heijden EA, Rahimtoola H, Leufkens HG, et al. Neurology. 10 October 2006. Vol.67. No.7. p.1128-34.
Reviewed by Dr Jim Vause

Review: A retrospective nested case-control study was used by these Dutch researchers to investigate whether the intensity of triptan and ergotamine use, in particular, overuse, is associated with the risk of ischaemic complications, They found that while triptan overuse, either not in or in combination with cardiac medications, was not associated with an increased risk, the overuse of ergotamine was a risk factor, especially in conjunction with cardiac medications.

Comment: Certainly something we need to be aware of, especially in patients with a higher risk of ischaemia. Given that migraines are associated with a higher risk of strokes, this is a sobering thought.

27-062 Triptan and ergotamine overuse in patients with headache at risk for vasoconstrictive complications

Obermann M, Katsarava Z. Neurology. 10 October 2006. Vol.67. No.7. p.1111.
Reviewed by Dr Jim Vause

Review: See 27-061.

Physician-Patient Relations

27-063 'Right' way to 'do' illness? Thinking critical about positive thinking

McGrath C, Jordens CF, Montgomery K, et al. Intern Med J. October 2006. Vol.36. No.10. p.665-8.
Reviewed by Dr Helen Moriarty

Review: Considers 'what is positive thinking?', and what it means to patients and health professional. Does it have benefits in health, or is it misleading? Should clinicians prescribe or subscribe to positive thinking?

Comment: Good thought-provoking stuff.

Preventive Medicine and Screening

27-064 Should women 40 to 49 years of age be offered mammographic screening?

Trop I, Deck W. Can Fam Physician Med Fam Can. September 2006. Vol.52. p.1050-2.
Reviewed by Dr Mike Lyons

Review: In this clinical debate, Dr Trop, an assistant professor of radiology, answers yes and is opposed by Dr Deck, a director of public health. Scientific reasoning is supplied to support the opposing views. Dr Trop argues that in 1995 in Canada more breast cancer cases were diagnosed in women 40–49 than 50–59, a Swedish study demonstrated 48% reduction in mortality from screening women in their 40s, 'harm' done by mammography is overstated and public policy is partially dictated by funding. Dr Deck opposes by stating that evidence for screening women in their 40s is weak, with real drawbacks, the overall benefit of screening can be evaluated based on a women's risk profile and the usefulness of mammography demonstrated by an initial test, and that GPs are well positioned to evaluate the risk of cancer and benefits of mammographic screening on a case-by-case basis.
Comment: As the Tui ads say – Yeah Right (to the latter position). I was more swayed by the affirmative.

27–065 1000 mg calcium and 400 IU vitamin D not very effective for fracture prevention

J Fam Pract. May 2006. Vol.55. No.5. p.386.
Reviewed by Dr Bruce Adlam
Review: In this sub-study of the Women's Health Initiative, 36 282 women were randomised to receive either 1000 mg calcium and 400 I vitamin D per day or placebo. A previous meta-analysis limited to studies in which women received more than 400 I (700 I to 800 I) of vitamin D found a significant 37% reduction in vertebral fractures (Endocr Rev 2002; 23:560-569). However, the ability of a small dose of calcium and vitamin D to prevent fractures in healthy community-dwelling women is modest at best. The authors point out this study used a relatively low dose of vitamin D, and the patients were generally at low risk of fracture and felt this might explain the discordance of these findings with the bulk of the literature on this topic. (LOE=1b) After a mean of seven years, there was a nonsignificant trend toward fewer hip fractures (0.14% vs 0.16% per year) and a similar nonsignificant trend toward fewer total fractures (1.64% vs 1.70%). (Original article reviewed: N Engl J Med 2006; 354: 69-683).

Psychiatry and Psychology

27–066 Interventions for adolescent depression in primary care

Stein RE, Zitner LE, Jensen PS. Pediatrics. August 2006. Vol.118. No.2. p.669-82.
Reviewed by Dr Jocelyn Tracey
Review: This article reviews the evidence for psychosocial, educational and supportive intervention strategies. There is evidence for the benefit of brief supportive interventions in primary care. One effective strategy described in the paper involved inviting teens in for a nurse consultation to discuss health behaviour concerns.
Comment: This article reviews the evidence rather than providing practical advice, but does provide many useful summaries of studies and references.

Respiratory System

27–067 Overnight prescription of oxygen in long term oxygen therapy: time to reconsider the guidelines?

Nisbet M, Eaton T, Lewis C, et al. Thorax. September 2006. Vol.61. No.9. p.779-82.
Reviewed by Dr Jim Vause
Review: To determine the prevalence of overnight desaturation in patients with COPD on long-term oxygen therapy (LTOT) researchers in Auckland, New Zealand performed a cross sectional prospective study of consecutive patients with COPD on LTOT. They found that overnight desaturation occurred in 16% of patients. Desaturators had mean resting oxygen saturation on room air of 88% compared with 90% in non-desaturators and corrected saturations of 93% versus 94%. Health-related quality of life and sleep quality were poor but did not differ between desaturators and non-desaturators.
Comment: This suggests that our current guidelines on LTOT with respect to increasing overnight flow rates needs reviewing. It might also account for why some patients can stop their oxygen at night without too much problem.

27–068 Angry breathing: a prospective study of hostility and lung function in the Normative Aging Study

Kubzansky LD, Sparrow D, Jackson B, et al. Thorax. October 2006. Vol.61. No.10. p.863-8.
Reviewed by Dr Jim Vause
Review: This might seem to be a little off beat but researchers in Boston, USA prospectively examined a cohort of 670 men who had an average of three pulmonary function examinations obtained over an average of 8.2 years of follow up. They compared hostility using the Cook-Medley Hostility Scale with FEV1 and FVC. They found that baseline pulmonary function differed between high and medium/low hostility groups. This overall association between higher hostility and reduced lung function remained significant after adjusting for smoking and education, although the effect size was attenuated for both FEV1 and FVC. Higher hostility was associated with a more rapid decline in lung function, and this effect was unchanged and remained significant for FEV1 in multivariate models but was attenuated for FVC.
Comment: Does angry breathing make you a blow hard? A fascinating study linking the biomedical with the psychosocial.

27–069 Controlled delivery of high vs low humidity vs mist therapy for

croup in emergency departments: A randomized controlled trial

Scolnik D, Coates AL, Stephens D, et al. JAMA. 15 March 2006. Vol.295. No.11. p.1274-80.

Reviewed by Dr Raina Elley

Review: Humidity treatment was not helpful in children with moderate croup seen in the Emergency Department. The 'blow-by' humidity technique has been shown to be ineffective in the past (a bit like blowing humid air or a steamy room) but it was hypothesised that if the humidity was controlled or the right droplet size, it may improve the 'Westley croup score' or reduce the need for effective treatments for severe croup (e.g. corticosteroid, adrenaline and intubation). This RCT compared controlled humidity delivery at 40%, controlled humidity at 100% at a droplet size specific for laryngeal deposition, and 'blow-by' humidity but found no difference in any of the outcomes between the groups.

Comment: 'Mist' or 'humidity' therapy have been used since the 19th century for croup but there is little evidence for efficacy and there are reports of harm, such as precipitating bronchospasm, hot water scalds, pulmonary changes and even hyponatraemia in the new-born.

27-070 Bronchiectasis

King P, Holdsworth S, Freezer N, et al. Intern Med J. November 2006. Vol.36. No.11. p.729-37.

Reviewed by Dr Helen Moriarty

Review: A review article that looks at the clinical features of bronchiectasis, what is known and still unknown of this long-described condition. CT scans make for good pictorial revision. The complexities of antibiotic choice are discussed. Antibiotics have changed the natural history of bronchiectasis.

Comment: A good revision paper on the topic.

27-071 Vulnerability of pulmonary capillaries during severe exercise

West JB. Br J Sports Med. 1 October 2006. Vol.40. No.10. p.821.

Reviewed by Dr Chris Milne

Review: The pulmonary capillaries are vulnerable to mechanical failure. At the base of the lung, transmural pressure in some capillaries can be up to 40 mm Hg. At times, this can result in disruption of the capillary and alveolar epithelium. If this is severe, it can result in haemoptysis (such a finding is very common in thoroughbred race horses).

Comment: For those patients who complain of a taste of blood after extreme exercise, there is a logical explanation. An excellent short article by one of the doyens of respiratory physiology.

27-072 Diagnosis and management of bronchiolitis

Pediatrics. October 2006. Vol.118. No.4. p.1774-93.

Reviewed by Dr Jocelyn Tracey

Review: An extensive literature review with evidence-based guidelines for the management of bronchiolitis.

Comment: The recommendations are largely around what is NOT required, e.g. investigations, bronchodilators, steroids.

Rheumatic Diseases

27-073 EULAR recommendations for knee and hip osteoarthritis: a critique of the methodology

Zhan W, Doherty M. Br J Sports Med. 1 August 2006. Vol.40. No.8. p.664-9.

Reviewed by Dr Chris Milne

Review: Two sets of guidelines for management of OA were reviewed. They attempt to fill the gap between guidelines based solely on either research evidence or expert opinion. A Delphi approach was used to sift through various expert opinions.

Comment: For the practising GP, the final set of 10 recommendations is the most useful part of the article. It appears as Table 2, and with magnification, serves as a good one page how-to guide.

Sexually Transmitted Diseases

27-074 Condom use and the risk of genital human papillomavirus infection in young women

Winder RL, Hughes JP, Feng Q, et al. N Engl J Med. 22 June 2006. Vol.354. No.25. p.2645-54.

Reviewed by Dr Raina Elley

Review: Regular condom use (100% of contacts) by male partners was associated with a much lower incidence of HPV infection (37.8 per 100 patient-years) in young women compared with intermittent use (<5%), which resulted in much higher rates (89.3 per 100 patient-years). There was also a trend towards much lower cervical squamous intraepithelial lesions in a post-hoc analysis (i.e. no lesions per 32 patient-years in regular condom group, and 14 lesions in intermittent condom group).

Comment: This was a prospective study over 12 months of 82 newly sexually active female University students. The results refute claims from previous cross-sectional studies that condoms are not protective against HPV. See also 27-075.

27-075 Condoms and sexually-transmitted infections

Steiner MJ, Cates W. N Engl J Med. 22 June 2006. Vol.354. No.25. p.2642-3.

Reviewed by Dr Raina Elley

Review: See 27-074.

Smoking

27-076 Tobacco use and risk of myocardial infarction in 52 countries in the INTERHEART study: a case-control study

Teo KK, Ounpuu S, Hawken S, et al. Lancet. 19-25 August 2006. Vol.368. No.9536. p.647-58.

Reviewed by Dr Tony Hanne

Review: A hundred million people died prematurely from the effects of smoking during the 20th century, more than the number who died in both world wars. A billion people will die, an average of 22 years early, in

the 21st century if smoking continues at the present rate. It takes at least 20 years for the excess risk of smoking to disappear after quitting. 82% of smokers are in developing countries. The risk of second hand smoking has now been quantified.
Comment: There is nothing new in this carefully constructed study except the stark reality of the numbers involved. They have some power of persuasion. Today I told one of my long-term resistant male smokers that he risked dying 22 years early and he left my surgery looking visibly shaken! See also comment 27-077.

27-077 The heart-breaking news about tobacco: it's all bad

Rosner SA, Stampfer MJ. Lancet. 19-25 August 2006. Vol.368. No.9536. p.621-2.
Reviewed by Dr Tony Hanne
Review: See 27-076.

Sports and Sports Medicine

27-078 Case proven: exercise associated hyponatraemia is due to overdrinking. So why did it take 20 years before the original evidence was accepted?

Noakes TD, Speedy DB. Br J Sports Med. 1 July 2006. Vol.40. No.7. p.567-72.
Reviewed by Dr Chris Milne
Review: For years, athletes have been exhorted to drink freely to prevent dehydration. Inevitably, some people drank to excess and became hyponatraemic. The evidence took years to be accepted because it conflicted with the prevalent message of the sports drink industry.
Comment: A major review article on an important topic for endurance athletes. Hyponatraemia is a common problem in events of over four hours' duration, and a lot of the ground breaking research was performed in Auckland by Dr Dale Speedy.

27-079 Is fatigue all in your head? A critical review of the central governor model

Weir JP, Beck TW, Cramer JT, et al. Br J Sports Med. 1 July 2006. Vol.40. No.7. p.573-86.
Reviewed by Dr Chris Milne
Review: The central governor model, proposed by Noakes and colleagues, proposes that the subconscious brain regulates power output to prevent catastrophic physiological failure. Weir and co-authors argue that peripheral factors other than lactic acid are known to compromise muscle power.
Comment: This 'task specific' model has some appeal, but there is not enough evidence to debunk the central governor model. There is a strong rebuke by Noakes and colleagues published in conjunction with this article (see the commentary at the end of this article).

27-080 Sailing and sports medicine: a literature review

Allen JB, De Jong MR. Br J Sports Med. 1 July 2006. Vol.40. No.7. p.587-93.
Reviewed by Dr Chris Milne
Review: This article describes the common sailing related injuries (back and knee problems) plus describes the physiology of small boat racing (in essence sustained quadriceps contractions with dinghy hiking, and varied activities for other crews).
Comment: With 75 references, this is an excellent introductory article, and it includes several references from a major sailing science conference in Palmerston North, published in 2003.

27-081 Physeal injuries in children's and youth sports: reasons for concern?

Caine D, DiFiori J, Maffulli N. Br J Sports Med. 1 September 2006. Vol.40. No.9. p.749-60.
Reviewed by Dr Chris Milne
Review: Physeal injuries are graded according to the Salter-Harris classification. Traditionally, Type I and Type II injuries have been thought to be relatively innocuous. These authors have found evidence of occassional localised growth plate closure and osseous bridging. These reports relate to young athletes from a variety of sports.
Comment: Useful addition to our knowledge. This is a very detailed article with 158 references.

27-082 Decrease in eccentric hamstring strength in runners in the Tirol Speed Marathon

Koller A, Sumann G, Schobersberger W, et al. Br J Sports Med. 1 October 2006. Vol.40. No.10. p.850-2.
Reviewed by Dr Chris Milne
Review: It is known that eccentric local muscular endurance of the knee flexors (hamstrings) correlates with running economy. These authors showed that 18 hours after finishing a marathon, a group of 13 runners showed reduced eccentric hamstring function when tested on an isokinetic dynamometer.
Comment: These authors have demonstrated what we may have intuitively suspected – tired muscles do not function well. There is good reason for athletes recovering from knee injuries, particularly ACL ruptures, to restrict themselves to non-fatiguing activities.

27-083 Classification of functional recovery of anterior cruciate ligament copers, non-copers, and adapters

Button K, van Deursen R, Price P. Br J Sports Med. 1 October 2006. Vol.40. No.10. p.853-9.
Reviewed by Dr Chris Milne
Review: ACL injuries are common, and not all patients are candidates for surgical reconstruction. These authors used a digital camcorder to analyse gait post-injury. A minimum of three recordings were made between zero and five months post injury. Copers returned to their pre-injury level of work or sport. Adapters reduced their activity level, to prevent giving way. Non-copers had episodes of instability even with ADL or non-pivoting sports. Post injury,

copers made the quickest return to normal gait velocity, adaptors were intermediate, and non-copers failed to regain normal gait velocity.
Comment: This study shows that by 40 days post injury, we have a relatively simple measure that can provide some idea of the longer-term prognosis following ACL rupture.

27-084 Does stretching increase ankle dorsiflexion range of motion? A systematic review

Radford JA, Burns J, Buchbinder R, et al. Br J Sports Med. 1 October 2006. Vol.40. No.10. p.870-5.
Reviewed by Dr Chris Milne
Review: These authors conducted a meta-analysis of randomised trials examining calf muscle stretches. They found that stretching for up to 15 minutes improves ankle dorsiflexion by two degrees, and for 15–30 minutes, by three degrees. The authors comment that these changes are small and statistically relevant, but it is unclear whether they are clinically important.
Comment: When examined in conjunction with the results of the work in the same issue of Br J Sports Med (see 27-085) of de Norontia et al., there may be some clinical relevance in terms of reducing lateral ligament ankle sprains. This is potential work for the future.

27-085 Do voluntary strength, proprioception, range of motion, or postural sway predict occurrence of lateral ankle sprain?

de Noronha M, Refshauge KM, Herbert RD, et al. Br J Sports Med. 1 October 2006. Vol.40. No.10. p.824-8.
Reviewed by Dr Chris Milne
Review: Because ankle sprains are so common, it is good to look for predictors of injury. From analysis of 7624 articles, 21 of which met inclusion criteria, the following were the strongest predictors of injury: limited dorsiflexion, impaired postural control, and perhaps poor proprioception. The authors comment that perhaps these variables interact to increase the risks of ankle sprains. (see also 27-084)
Comment: For such a common injury, it is sobering that we have only limited research evidence on which to base our advice to patients.

27-086 Clinical examination of the foot and ankle

Young CC, Niedfeldt MW, Morris GA, et al. Prim Care. March 2005. Vol.32. No.1. p.105-32.
Reviewed by Dr M Hewitt
Review: A useful, helpful review with analysis of ambulatory anatomical components of the foot and ankle.

27-087 Ankle and foot injuries in pediatric and adult athletes

Pommering TL, Kluchurosky L, Hall SL. Prim Care. March 2005. Vol.32. No.1. p.133-61.
Reviewed by Dr M Hewitt
Review: A very comprehensive outline, with a simple, informative discussion and excellent photography and illustrations of the relevant anatomy.
Comment: Better than a text book and much cheaper.

27-088 Groin injuries and groin pain in athletes: part 1

Morelli V, Weaver V. Prim Care. March 2005. Vol.32. No.1. p.163-83.
Reviewed by Dr M Hewitt
Review: The authors note the prevalence of these injuries in high school athletes as being between 5% and 9%. Careful consideration of these injuries is important given the complex anatomy and the significant long-term adverse affects on the athletes concerned.
Comment: Excellent illustrations accompanied by straightforward text (see 27-089).

27-089 Groin injuries and groin pain in athletes: part 2

Morelli V, Espinoza L. Prim Care. March 2005. Vol.32. No.1. p.185-200.
Reviewed by Dr M Hewitt
Review: See 27-088.
Comment: Read and profit thereby.

27-090 Lower back pain in the athlete: common conditions and treatment

Baker RJ, Patel D. Prim Care. March 2005. Vol.32. No.1. p.201-29.
Reviewed by Dr M Hewitt
Review: There are overlapping similarities between low back pain in athletes and the general population. This article looks in depth at the more specific and likely pathology in the athlete.

27-091 Cervical pain in the athlete: common conditions and treatment.

Dorshimer GW, Kelly M. Prim Care. March 2005. Vol.32. No.1. p.231-44.
Reviewed by Dr M Hewitt
Review: Neck injuries are among the more serious as they are frequently as the result of acute trauma. Signs and symptoms and anatomy of the neck region are well dealt with.

27-092 Basic biomechanics of the lower extremity

Fields KB, Bloom OJ, Priebe D, et al. Prim Care. March 2005. Vol.32. No.1. p.245-52.
Reviewed by Dr M Hewitt
Review: The authors describe the common principles of biomechanics for the activities of jumping, running, and kicking.
Comment: Pre-requisite knowledge for primary care sports physicians.

27-093 Sports-related osteochondral injuries: clinical presentation, diagnosis, and treatment

Bruce EJ, Hamby T, Jones DG. Prim Care. March 2005. Vol.32. No.1. p.253-76.
Reviewed by Dr M Hewitt
Review: Osteochondral injuries are more common in younger athletes and relate to the load placed on the joints. This knowledge is useful for diagnostic purposes as it can mean the differences between operative and non-operative therapy.

27-094 Sports pharmacology and ergogenic aids

Ellender L, Linder MM. Prim Care. March 2005. Vol.32. No.1. p.277-92.
Reviewed by Dr M Hewitt

Review: An analysis of some of the products athletes use to improve performance. The evidence basis for their effectiveness as well as their legality according to Olympic Sports Standards are discussed.

Comment: Not comprehensive but good to get some of the 'borderline' products in print. The more we know about what our patients are using or likely to encounter, the better for all concerned.

Therapeutics

27-095 Non-steroidal anti-inflammatory drugs in athletes

Lippi G, Franchini M, Guidi GC. Br J Sports Med. 1 August 2006. Vol.40. No.8. p.661-3.
Reviewed by Dr Chris Milne

Review: NSAIDS are widely prescribed drugs. This article describes the major clinical effects and side effect profile of these agents. It is accompanied by a useful commentary describing the latest guidelines for NSAID use. In total, there are 35 references.

Comment: A good general article, with an even better commentary. To my mind the commentary under-estimates the potential GI benefits of prescribing COX-2 agents.

Urology

27-096 Benign prostatic hypertrophy: Update on drug therapy

Tejani A, Musini V, Perry TL, et al. Can Fam Physician Med Fam Can. September 2006. Vol.52. p.1075-6.
Reviewed by Dr Mike Lyons

Review: Succinct two-page article update on the evidence of benefits and side effects from alpha-blockers and 5-alpha reductase inhibitors.

Comment: Suggests men set their own treatment goals of symptom relief and we inform them realistically re long-term limited options.

Instructions for authors
New Zealand Family Physician publishes original papers on general practice and family medicine. We encourage editorials, case reports and invite readers to contribute to regular features.

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.

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

References
Refer to published material by inserting numbers serially in the text. List no more than 20 references on the last page in the order cited in the text. Abbreviate journal names in the style of Index Medicus, and refer to journal articles as follows: authors' surnames and initials, title of article, abbreviated name of journal, year, volume number, first and last page numbers. Refer to books as follows: authors, title of chapter, title of book, edition, publishing house and city, year, page numbers referred to. Check the accuracy of every reference.

Illustrations
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.

Competing interests
All authors will be asked to declare competing interests.

Publishing dates
New Zealand Family Physician is published six times annually, in February, April, June, August, October and December. Original papers are submitted to referees before being accepted for publication, and are published as soon as space permits.

Subscriptions
The journal is provided free to all members of the RNZCGP. Rates for others are $132 per year within New Zealand, $174 outside New Zealand (including postage). The Royal New Zealand College of General Practitioners, P O Box 10440, Wellington, New Zealand.

Editor
Dr Tony Townsend MGP (Otago) BSc FRNZCGP Dip Obst.

Editorial Board
Dr Bruce Arroll, Dr Andrew Divett, Professor Tony Dowell, Dr Pamela Hyde, Professor Marjan Kljakovic, Dr Lynette Murdoch, Mr Andrew Stenson, Dr Jocelyn Tracey, Dr Jo Scott-Jones.

Emeritus Editors
Professor Campbell Murdoch, Dr Ian St George, Dr Tessa Turnbull, Dr Rae West, Dr David Cook.

Management
Hugh Sutherland

Designer
Robyn Atwood

Advertising enquiries:
Colin Gestro ph: 09–489 8911, fax: 09–489 8941, email: colingestro@affinityads.com

All other correspondence to:
Cherylyn Pearson, Publications Administrator
Royal New Zealand College of General Practitioners
P O Box 10-440, WELLINGTON
Email: nzfp@rnzcgp.org.nz

The *New Zealand Family Physician* is the official journal of the RNZCGP, however, views expressed are not necessarily those of the College, the editor, or the editorial board.

The Royal New Zealand College of General Practitioners