Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Acupunct Med*
Am Fam Physician*
Am J Vet Res*
Arch Phys Med Rehabil*
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Can Fam Physician Med Fam Can*
Evidence-Based Medicine*
J Fam Pract*
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N Engl J Med*
Neurosci Lett*
Patient Care*
Physician and Sportsmedicine*
Postgrad Med*
Prim Care*
*Journals indexed in Medline

Acupuncture

23–157 Treatment of hot flushes in breast cancer patients with acupuncture.

Tukmachi E. Acupunct Med. June 2000. Vol.18. No.1. p.22-7.
Reviewed by Dr Alex Chan

Review: Twenty-two breast cancer patients with disturbing hot flushes were treated by individualised course of acupuncture using a standardised formula, together with advice on lifestyle, diet, and short-term fasting. Significant reductions in both day and night frequencies of hot flushes were noted at end of treatment with reduction of averaged daytime flushes from 14.32 to 1.41 and nocturnal flushes from 6.95 to 0.86. This was maintained on follow-up at three to five weeks.
Comment: This clinical study showed the combined effects of acupuncture, lifestyle and diet advice and short-term fasting on hot flushes. No control group was used, and only short term follow-up results were available. However, this approach could be a worthwhile option for some breast cancer patients. Read the original article for the acupoints prescription.

23–158 Is acupuncture effective in treating chronic pain after spinal cord injury?

Nayak S, Shiflett SC, Schoenberger NE, et al. Arch Phys Med Rehabil. November 2001. Vol.82. No.11. p.1578-86.
Reviewed by Dr Alex Chan

Review: Effect of acupuncture on chronic pain and secondary symptoms after spinal cord injury were assessed in this pilot study. Forty-six per cent of patients (10/22) showed improvement in pain intensity and pain sequelae after treatment. Patients with pain located above level of injury responded better to treatment. Forty-two per cent of patients with central pain and 80% with musculoskeletal pain experienced pain relief. Expectation of response was not associated with the amount of pain relief obtained. However, a small group reported slight increase in pain after treatment.
Comment: High quality research led by the New Jersey Medical School. Combinations of body and ear acupoints were used, but ear acupoints not specified. Good reference list of assessment instruments which might be useful for someone attempting to carry out clinical acupuncture research.

23–159 Unique immunomodulation by electro-acupuncture in humans possibly via stimulation of the autonomic nervous system.

Mori H, Nishijo K, Kawamura H, et al. Neurosci Lett. 1 March 2002. Vol.320.

journal review service

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The JRS is a guide to current reading in General Practice. Each article reviewed in the JRS has been selected by the reviewer because, in some aspect, it is considered worth reading by general practitioners.

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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THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

No.1-2. p.21-4.
Reviewed by Dr Alex Chan
Review: The effect of electro-acupuncture (at 1 Hz for 20 minutes, using acupoints LI-4 and LU-7) on the granulocytes and lymphocytes in the blood and on the heart rate was observed in 40 normal subjects. Acupuncture was found to normalise the pattern of leukocytes and induce a decrease in the heart rate. It was postulated that acupuncture could modulate the immune system via its effect on the autonomic nervous system.
Comment: The experimental results suggested possible mechanisms for the beneficial effect of acupuncture on some chronic diseases or infections. Simple experiment, but no particular explanation was given for the selection of acupoints used in the study. Could other acupoints lead to similar results?

23-160 Electroacupuncture-induced neural activation detected by use of manganese-enhanced functional magnetic resonance imaging in rabbits.

Chiu JH, Cheng HC, Tai CH, et al. Am J Vet Res. February 2001. Vol.62. No.2. p.178-82.
Reviewed by Dr Alex Chan
Review: Electroacupuncture was applied to acupoints ST-36 and GB-34 in anaesthetised rabbits. Manganese-enhanced fMRI was performed five and 20 minutes after initiation of electroacupuncture. Stimulation of ST-36 for five minutes resulted in activation of the hippocampus, whereas stimulation on GB-34 resulted in activation of the hypothalamus, insula, and motor cortex. Activation became less specific after 20 minutes of electroacupuncture. Furthermore, stimulation on ipsilateral acupoints led to bilateral brain activation.
Comment: Manganese-enhanced fMRI provides an approach to direct imaging of brain function. The study showed that each acupoint had a corresponding cerebral linkage. It also provided a possible explanation for the specific use of GB-34 stimulation in musculoskeletal conditions. Forty New Zealand white rabbits were used in this study!

Alcohol Drinking

23-161 Acute care for alcohol intoxication: Be prepared to consider clinical dilemmas.

Yost DA. Postgrad Med. December 2002. Vol.112. No.6. p.14-26.
Reviewed by Dr Chris Milne
Review: Comprehensive review of all you need to know when faced with the acute drunkard. Be on the lookout for coexistent trauma and use of other drugs in addition to alcohol. Therapy may include IV fluids for rehydration, glucose for hypoglycaemia, correction of electrolyte imbalances e.g. hypomagnesemia, plus symptomatic control of nausea and vomiting.
Comment: Despite its American origins, this article succinctly and comprehensively covers the important points. Useful table showing the blood alcohol concentration after varying intakes of standard drinks (e.g. five to eight drinks in a 90kg person will give a blood alcohol of 100–150 mg/100ml. To attain the same level in a 55kg person takes only three to five drinks).

Alternative Medicine

23-162 Cardiovascular disease.

Gavagan T. Prim Care. June 2002. Vol.29. No.2. p.323-38.
Reviewed by Dr M Hewitt
Review: The main part of the review concentrates on the proven benefits of dietary intervention for the prevention of cardiovascular disease. The primary example given is derived from the American Heart Foundation recommended diet and DASH. Other approaches such as vitamin supplementation, herbal therapy and mind-body remedies are useless. Chelation therapy has not been able to show significant benefit in controlled clinical trials.
Comment: As expected and much in keeping with our own National Heart Foundation guidelines.

23-163 Anxiety, depression, and insomnia.

Larzelere MM, Wiseman P. Prim Care. June 2002. Vol.29. No.2. p.339-60.
Reviewed by Dr M Hewitt
Review: The evidence for effective alternative treatments for depression, anxiety and insomnia was examined for St John's wort, L-tryptophan (LT), 5-Hydroxytryptophan (5-HTP), S-adenosylmethionine (SAM-e). Evidence-based studies revealed St John's wort to be effective but response rates no different to low dose tricyclic antidepressants. LT was also effective as treatment compared to placebo. For acupuncture, herbs and supplements and meditation there was no convincing evidence for the treatment of depression and/or anxiety over placebo. However, using the

same criteria, exercise showed a moderate mood improvement among men and women of all ages.

23-164 Acupuncture.

Nasir LS. Prim Care. June 2002. Vol.29. No.2. p.393-405.

Reviewed by Dr M Hewitt

Review: The author gives a brief history and physical description of the application of acupuncture and its biologic effects. He outlines that 13 controlled trials from 1976 to 1989 reported acutherapy superior to no treatment or sham treatment. One single-blind randomised placebo-crossover trial for chronic low back pain showed acutherapy superior to placebo.

Comment: It does not appear to have been demonstrated as effective in fibromyalgia, rheumatoid arthritis, osteoarthritis, asthma or CVA sequelae. Nor is it effective for depression. While it has been demonstrated as more effective for some conditions than placebo it has not been favourably compared in trials to other proven, efficacious treatment modalities.

23-165 Homeopathy.

D'Huyvetter K, Cohrssen A. Prim Care. June 2002. Vol.29. No.2. p.406-18.

Reviewed by Dr M Hewitt

Review: One of the reviewers is a non-medical practising homeopath. She gives a brief history of the practice and an explanation of the mechanism of action. The supporting evaluating studies used animals such as mice and non-randomised trials in humans. These favoured homeopathic remedies. Where such trials were available for meta analysis, which were randomised, homeopathy was found not to be effective for asthma, influenza, migraine headaches, plantar warts, osteoarthritis and weight loss.

23-166 Chiropractic.

Dagenais S, Haldeman S. Prim Care. June 2002. Vol.29. No.2. p.419-37.

Reviewed by Dr M Hewitt

Review: This is a description and overview of chiropractic theory, education, licensure and use in the United States. The review mentions the results of major reviews in the United States, Denmark, New Zealand, Australia, UK and Sweden for guidelines and recommendations for low back pain.

Comment: At best, all the studies suggest this is a palliative form of physical therapy.

Analgesia and Anesthesia

23-167 Recent developments: Management of pain.

Holdcroft A, Power I. BMJ. 22 March 2003. Vol.326. No.7390. p.635-9.

Reviewed by Dr Len Brake

Review: With advances in neurobiology there is expectation of better pain control from patients and health professionals. There is a move from an empirical approach to a pain-mechanism based approach. Evidence-based medicine plans for back pain are included in this clinical review.

Comment: This is an update on developments in the pain field and very relevant to all.

Asthma

23-168 Accessibility, acceptability, and effectiveness in primary care of routine telephone review of asthma: pragmatic, randomised controlled trial.

Pinnock H, Bawden R, Proctor S, et al. BMJ. 1 March 2003. Vol.326. No.7387. p.477-9.

Reviewed by Dr Len Brake

Review: This is a RCT of 278 asthmatics over four general practices in England. A comparison is made of face to face consultations versus telephone reviews for asthma medication and progress. With the PHO system looming this is the type of approach to chronic illness management likely to be seen in NZ. In this trial more patients were managed in a shorter time at a cheaper cost. There was no apparent clinical disadvantage.

23-169 Do written action plans improve patient outcomes in asthma? An evidence-based analysis.

Lefevre F, Piper M, Weiss K, et al. J Fam Pract. October 2002. Vol.51. No.10. p.842-8.

Reviewed by Dr Bruce Adlam

Review: This systematic review of published studies suggests that although action plans are widely used there is insufficient evidence to determine whether their use with or without peak flow monitoring improves outcomes.

Cardiovascular System

23-170 2001 Canadian hypertension recommendations: What has changed?

Canadian Hypertension Recommendations Working Group. Can Fam Physician Med Fam Can. October 2002. Vol.48. p.1662-5.

Reviewed by Dr Mike Lyons

Review: This article from the Canadian Hypertension Recommendations Working Group starts with the bold statement *'Canada is the only country with comprehensive, annually updated hypertension recommendations that are compiled using a systematic evidence-based approach.'* It proceeds to highlight the changes suggested in 2001 and draws attention to more aggressive treatment of diabetic and post acute phase of stroke patients. *'Diagnosis requires up to five visits if there is no target organ damage and the initial BP is below 180/105.'* It suggests sensible initial screening for essential and secondary hypertension. Drug therapy is tabled.

Comment: Useful if you need more guidance in treating hypertensive patients. Despite clear recommendations, *'one in five adult Canadians have high BP, and only 16% of hypertension cases are treated and controlled'.* Food for thought in the new PHO NZ environs.

23-171 Prevention of coronary and stroke events with atorvastatin in hypertensive patients who have average or lower-than-average cholesterol

concentrations, in the Anglo-Scandinavian Cardiac Outcomes Trial–Lipid Lowering Arm (ASCOT-LLA): a multicentre randomised controlled trial.

Sever PS, Dahlof B, Poulter NR, et al. Lancet. 5 April 2003. Vol.361. No.9364. p.1149-58.

Reviewed by Dr Tony Hanne

Review: Over 19 000 patients were treated with atorvastatin 10mg daily as described in the paper title. The intention had been to treat for five years but the trial was abandoned on ethical grounds after 3.3 years because the benefit of treatment over placebo was already large. The number of events in the treated group was only 100 compared with 154 in the placebo group. The number of deaths was reduced by 27. Results were similar regardless of whether patients were diabetic, smokers, obese or had previous vascular or renal disease. No benefit, however, was found in women. There were no significant adverse effects of treatment.

Comment: These results are consistent with other trials and pose huge problems for health funders. One assumes there might be some embarrassment among bureaucrats who have tried for years to persuade us that statins should only be used at very high levels of cholesterol because they would not benefit others. Surely even in dollar terms it is cheaper to treat appropriately with statins than to have the cost of hospital treatment and of premature disablement or death in the substantial numbers demonstrated by this trial.

23-172 Informed consent during the clinical emergency of acute myocardial infarction (HERO-2 consent substudy): a prospective observational study.

Williams BF, French JK, White HD. Lancet. 15 March 2003. Vol.361. No.9361. p.918-22.

Reviewed by Dr Tony Hanne

Review: A group of NZ cardiologists were brave enough to do a study on the ethics of their own study and to publish the unsatisfactory results. The question was whether the informed consent process was truly autonomous in a trial of reperfusion after acute myocardial infarction. The problems were that the language of the patient information sheet was frequently beyond the educational level of the patient, usually was not read, and that judgement was clouded by anxiety and morphine.

Comment: The recommendations of the researchers are that as well as writing in simpler language, patient information should be quietly, simply and concisely explained verbally. This excellent study confirms what most of us in general practice already know, that most of our patients participating in hospital-based trials have not got a clue about what is being done to them.

23-173 Losartan reduced cardiovascular morbidity and mortality more than atenolol in patients with diabetes and essential hypertension.

Blecker D, Blecker SB. Evidence-Based Medicine. November/December 2002. Vol.7. No.6. p.173-4.

Reviewed by Dr Bruce Arroll

Review: These two papers compare losarten with atenolol in patients at high risk of CVD and with left ventricular hypertrophy. In the patients with diabetes and hypertension there was a reduction in CVD mortality and all cause mortality and heart failure for losarten compared with atenolol. Numbers needed to treat (NNT) of 28, 16 and 28. In the other study of patients at high risk of CVD without diabetes there was a reduction in stroke and the rate of new onset diabetes NNT of 61 and 52. (Original article reviewed: Lancet 2002 Mar 23; 359: 1004-10) See also 23-174.

23-174 Losartan reduced strokes and new onset diabetes more than atenolol in essential hypertension.

Blecker D, Blecker SB. Evidence-Based Medicine. November/December 2002. Vol.7. No.6. p.174.

Reviewed by Dr Bruce Arroll

Review: See 23-173 (Original article reviewed: Lancet 2002 Mar 23; 359: 995-1003).

23-175 Review: cardioselective ß-blockers did not reduce respiratory function in patients with chronic obstructive pulmonary disease.

Stanbrook MB. Evidence-Based Medicine. November/December 2002. Vol.7. No.6. p.181.

Reviewed by Dr Bruce Arroll

Review: This paper reviews the effect of cardioselective beta blockers on patients with COPD and their response to beta agonists. They found no evidence that they reduced respiratory function nor reduced the response of patients to beta-agonists. (Original article reviewed: Cochrane Database Syst Rev. 2002 (2): CD003566)

Comment: The commentator suggests careful monitoring when using cardioselective beta blockers. This is a cautious green light to give metoprolol to those heart failure patients with COPD.

23-176 Antioxidants do not prevent heart disease in high-risk individuals.

Johnson KH. J Fam Pract. October 2002. Vol.51. No.10. p.810.

Reviewed by Dr Bruce Adlam

Review: Impressive placebo controlled, double-blind, RCT of over 20 000 adults (mostly men) over five years clearly shows that antioxidants, specifically vitamin E, C, and beta-carotene should not be recommended for secondary prevention of heart disease. No differences were noted for cancer incidence or hospitalisation for any other nonvascular cause. (Original article reviewed: Lancet 2002; 360: 23-33)

Comment: Five years might be too short a duration to make any firm conclusions regarding effects on cancer.

23-177 ß-blocker survival benefit outweighs side-effect risks.

Easterling LP, Koval PG, McDiarmid T. J Fam Pract. October 2002. Vol.51. No.10. p.814.

Reviewed by Dr Bruce Adlam

Review: ß-blockers are not associated with a significant increase in depressive symptoms though they do cause a slightly higher incidence of fatigue and sexual dysfunction (more so propanolol). Later generation ß-blockers are recommended to reduce the risk of these side effects (e.g. metopralol, atenolol, etc.) Lipid solubility made no difference to the risks of side effects. (Original article reviewed: JAMA 2002; 288: 351-7)

Communicable Diseases, Infections and Parasites

23-178 Guideline on management of Severe Acute Respiratory Syndrome (SARS)

Ho W. Lancet. 19 April 2003. Vol.361. No.9366. p.1313-5.

Reviewed by Dr Bruce Adlam

Review: Useful article which contains management flowcharts in A&E departments for patients with a definite contact with SARS patients within the last 10 days.

Comment: The initial risk of SARS in NZ will be/is to health care workers. Half the cases of SARS in Singapore and Hong Kong are health care workers. These are the very people who should know how to protect themselves, yet they still become unwell. This is usually because they are unprotected at the time of first presentation. Close droplet spread is at the time of writing the principal mode of transmission. Some patients are more 'infective' than others. The rate of 'super spreaders' so far in Singapore is 4% or one per week in a country that has responded quickly and aggressively to local transmission. As a rule of thumb 90% of probable SARS patients have a less severe illness, 10% require ICU and half of these will require ventilation. Half the victims are health care workers and the impact on health services is hugely significant as an unprotected probable SARS case will take out three shifts of nurses, doctors and allied staff while they sit out quarantine. Closed adjacent wards impacts on the ability to provide normal services. Last but not least it will impact significantly on the safety of the country as a travel destination. (Dr Adlam currently works in the Ministry of Health, Singapore - editor)

23-179 A major outbreak of Severe Acute Respiratory Syndrome in Hong Kong.

Lee N, Hui D, Wu A, et al. N Engl J Med. 7 April 2003. Vol.online. p.1-9.

Reviewed by Dr Bruce Adlam

Review: This was one of the first articles to appear on SARS and describes the epidemiology and early clinical presentation of 138 probable SARS patients. Equal numbers of men and women are affected. Half were health care workers. 23.2% required ICU and five died (all of whom had co-existing conditions). Fever was present in 100%, chills/rigors in 73.2%, myalgia in 69%. Cough and headache also reported in more than 50%. Nausea, vomiting, diarrhoea in 20%, lymphopaenia occurred in 69%, and thrombocytopaenia in 44.8%. Elevated LDH 71% and CK 32%. Peripheral air space consolidation was commonly observed on CT. Multivariate analysis gives the following independent predictors of an adverse outcome. Advanced age, high LDH, absolute neutrophil count that exceeded upper limit of normal on presentation.

Comment: Very good article especially given the state of knowledge at the time.

Dermatology

23-180 Unraveling the mystery of rosacea: Keys to getting the red out.

Landow K. Postgrad Med. December 2002. Vol.112. No.6. p.51-8.

Reviewed by Dr Chris Milne

Review: Rosacea results from a disparate assortment of stimuli acting in concert on a genetically susceptible host. A flaw in the autonomic innervation of the cutaneous vasculature is the likely root cause of rosacea, which explains its links with migraine and the perimenopausal period (no pun intended!). Several subtypes of rosacea are listed, some

with associated telangiectasia or ocular symptoms.
Comment: This is a very detailed article about an often neglected condition. It's probably a lot more common than we recognise.

23-181 Topical steroids more effective than antifungals for chronic paronychia.

Rosebaum D, Merenstein D, Meyer F. J Fam Pract. October 2002. Vol.51. No.10. p.824.
Reviewed by Dr Bruce Adlam
Review: Did you know that? I didn't but this small well designed study showed topical steroids (methylprednisolone aceptonate cream .1%) was more effective than systemic antifungal (itraconazole, terbinafine) agents. Although Candida is often isolated from these nails its presence or absence appears to be unrelated to effective treatment of this disorder. Clinical improvement or cure of total nails at the end of six weeks was 85% for the topical steroid and 53% vs 45% for itraconazole and terbinafine respectively. Improvement or cure was observed on 60% of patients treated with steroid and 33% vs 20% for itraconazole and terbinafine respectively. (Original article reviewed: J Am Acad Dermatol 2002; 47: 73-6)
Comment: I'm impressed.

Ear, Nose and Throat

23-182 Why do general practitioners prescribe antibiotics for sore throat? Grounded theory interview study.

Kumar S, Little P, Britten N. BMJ. 18 January 2003. Vol.326. No.7381. p.138-43.
Reviewed by Dr Len Brake
Review: General practitioners have reduced prescribing for sore throat but factors influencing the decision are unclear. This paper attempts to tease out the reasons for prescribing. How, for example, can you tell if an infected throat is bacterial just by looking? Do you prescribe more freely if the patient is really unwell? What is the relationship between length of time in practice and rate of antibiotic prescribing?
Comment: Fascinating but the earth did not move for me.

Endocrinology

23-183 Musculoskeletal manifestations of diabetes mellitus.

Smith LL, Burnet SP, McNeil JD. Br J Sports Med. 1 February 2003. Vol.37. No.1. p.30-5.
Reviewed by Dr Chris Milne
Review: Frozen shoulder, carpal tunnel syndrome, flexor tenosynovitis and diffuse idiopathic skeletal hyperostosis (DISH or Forestier's disease) are all so much more common in diabetic people. Therefore, their diagnosis should prompt a request for blood glucose measurement, unless the patient is already a known diabetic.
Comment: This is a good reminder to look beyond the macro and microvascular disease that we tend to concentrate on, if we are going to make the maximal impact on this important disease.

23-184 Review: metformin does not increase fatal or non-fatal lactic acidosis or blood lactate concentrations in type 2 diabetes mellitus.

Sigal RJ. Evidence-Based Medicine. November/December 2002. Vol.7. No.6. p.176.
Reviewed by Dr Bruce Arroll
Review: This was a review of papers comparing metformin with non-metformin medication in terms of their association with lactic acidosis. They found no increase in the risk of lactic acidosis when comparing metformin with non-metformin groups. (Original article reviewed: Cochrane Database Syst Rev 2002 (2): CD002967)
Comment: The commentator claims that in contrast to phenformin no credible evidence exists linking metformin to an increase in lactic acidosis. He concluded saying that an overly restrictive contraindication to metformin might result in many people being denied an excellent drug while preventing few if any cases of lactic acidosis.

Guidelines

23-185 Guidelines of the American College of Obstetricians and Gynecologists for exercise during pregnancy and the postpartum period.

Artal R, O'Toole M. Br J Sports Med. 1 February 2003. Vol.37. No.1. p.6-12.
Reviewed by Dr Chris Milne
Review: These updated guidelines recommend medical screening before exercise, as there are significant absolute contraindications such as premature labour during the current pregnancy, ruptured membranes, second or third trimester bleeding and pregnancy induced hypertension. They recommend 30 minutes of exercise on most days of the week, with care not to raise core temperature by over 1.5°C. This can be achieved by self pacing to a maximum of 90% of maximal heart rate, and limiting duration of exercise to less than 45 minutes in most cases.
Comment: Useful guidelines, which help the few of us still seeing pregnant women to give them appropriate advice. I'm not sure how many midwives are aware of these guidelines, and implement them during pregnancy and the postpartum period.

Gynaecology

23-186 Do the risks of estrogen plus progestin outweigh the benefits in healthy postmenopausal women?

Lindbloom EJ. J Fam Pract. October 2002. Vol.51. No.10. p.821.
Reviewed by Dr Bruce Adlam
Review: HRT should not be used for the prevention of coronary artery disease. Other agents should be considered for osteoporosis. HRT may still be an option for the healthy post

menopausal women with significant vasomotor symptoms provided they are well informed of the risks and it is limited, if possible, to five years. (Original article reviewed: JAMA 2002: 288: 321-33)

23-187 What medications are effective for treating symptoms of premenstrual syndrome (PMS)?

Vleck JP, Safranek SM. J Fam Pract. October 2002. Vol.51. No.10. p.894.

Reviewed by Dr Bruce Adlam

Review: (a) Vitamin B6 50-100mg/day, Odds ratio 2.32 (Grade of recommendation: B); (b) Elemental Calcium 1200 mg/day, NNT=6 for 50% symptom reduction (Grade: B); (c) SSRI Fluoxetine, NNT 4-11 (Luteal phase dosing may be more effective); (d) Benzodiazepines Alprazolam 0.25-0.5 tds in luteal phase NNT=3 for 50% symptom reduction (Grade: B); (e) GnRH agonists (Danazol 200-400mg/d). Benefit unclear.

Comment: No convincing evidence of benefit from diuretics, magnesium, beta-blockers, lithium, progesterone, or vitamin E. Oral contraceptives are ineffective for global symptoms and may make PMS symptoms worse in some women. They may, however, benefit women with primarily physical symptoms (Grade of recommendation: B and C).

Immunology and Allergy

23-188 Evaluation and treatment of the patient with allergic rhinitis.

Conner SJ. J Fam Pract. October 2002. Vol.51. No.10. p.883-90.

Reviewed by Dr Bruce Adlam

Review: A common sense article. Look for physical clues. Skin prick testing can detect IGE antibodies in patients with reliable histories of exposure to allergens. Intranasal corticosteroids are superior to other medications and in some cases subcutaneous immunotherapy can achieve clinical remission for up to three years after cessation of treatment.

Law and Medicine

23-189 Patients' and physicians' attitudes regarding the disclosure of medical errors.

Gallagher TH, Waterman AD, Ebers AG, et al. JAMA. 26 February 2003. Vol.289. No.8. p.1001-7.

Reviewed by Dr Raina Elley

Review: Some studies from secondary care have shown that doctors sometimes do not disclose medical errors to patients because of fear of malpractice suits (complaints), damage to the doctor's reputation, and uncomfortable and awkward feelings. This study used qualitative analyses of thirteen focus groups of various combinations of physicians and patients, involving 52 (mostly white female) patients and 46 (mostly white male) physicians, to investigate the attitudes of patients and doctors about medical error disclosure. The study found that patients would like doctors to discuss all harmful errors with them, apologise, and provide emotional support after the error. There were mixed feelings about whether to disclose 'near misses'. Doctors also thought disclosures of errors were important as long as they 'chose their words carefully'. Doctors often felt upset when errors occurred, which surprised patients, but did not know where to seek support.

Comment: Mistakes happen in any walk of life. Medicine is no different. However, with increasing interest in finding ways to reduce medical error, feeling comfortable about identifying and discussing errors, may help to avoid similar errors in the future. However, a 'no blame environment' would encourage more disclosure.

Musculoskeletal System

23-190 Prevention and treatment of osteoporosis in postmenopausal women.

French L, Smith M, Shimp L. J Fam Pract. October 2002. Vol.51. No.10. p.875-82.

Reviewed by Dr Bruce Adlam

Review: This is a special sponsored section in this issue of the *Journal of Family Practice*. It is an American based study which will be of interest to those in the field but some caution may be required in generalising these findings to the NZ population.

Neurology

23-191 Headaches in children and adolescents.

Lewis DW. Am Fam Physician. 15 February 2002. Vol.65. No.4. p.625-32.

Reviewed by Dr J Corbett

Review: The evaluation of headache, from history to physical and neurological examination. Neuroimaging should be restricted to those with chronic-progressive patterns of headache or neurological abnormalities on examination. Treatments discussed especially for migraine. Patient handout included. For the editorial comment see 23-192.

Comment: Very useful review and helpful for diagnosis and who to refer for specialist input and/or neuroimaging.

23-192 Reducing headache disability in children and adolescents.

Marcus DA. Am Fam Physician. 15 February 2002. Vol.65. No.4. p.554-7.

Reviewed by Dr J Corbett

Review: See 23-191.

Nutrition

23-193 What are the most effective interventions to reduce childhood obesity?

Hill JC, Smith PC, Meadows SE. J Fam Pract. October 2002. Vol.51. No.10. p.891.

Reviewed by Dr Bruce Adlam

Review: Efforts to increase physical activity show short-term benefit. Dieting may be more effective along with aiming interventions at parents,

intensive family therapy, and comprehensive school based programmes.
Comment: No comment on the intensive hiding of the game boy, locking them out of the PC, and removal of the TV.

Oncology

23-194 A randomized trial of aspirin to prevent colorectal adenomas in patients with previous colorectal cancer.

Sandler RS, Halabi S, Baron JA, et al. N Engl J Med. 6 March 2003. Vol.348. No.10. p.883-90.
Reviewed by Dr Raina Elley
Review: There has been some evidence, from observational and animal studies, to suggest that regular aspirin use could be protective against colorectal adenomas as potential precursors to colorectal cancer. This double blind randomised controlled trial of 325 mg daily aspirin vs placebo, involved 635 randomly assigned individuals with previous colorectal cancer. The study was stopped early because of statistically significant decreases in the percent of intervention patients with adenomas (17%), found with colonoscopy, compared with control patients (27%, p=0.04), giving an adjusted relative risk of 0.65 (95% CI 0.46 to 0.91). Median follow-up time was 30.9 months in the intervention group and 31.6 months in the control group. Adverse events were minimised by excluding 'at risk' patients and those that experienced unacceptable side effects during the 'run in' phase.
Comment: Caution should be exercised before routinely using aspirin to prevent colorectal cancer recurrence. Analysis in this study was only carried out on 517 (81%) of randomised patients, being the ones who had had at least one colonoscopy after randomisation. It appears that an intention to treat analysis was not carried out, which may bias the results. The surrogate endpoint of adenoma occurrence, not colorectal cancer, was used in this study, although adenomas are likely to be precursors to cancer. It would be interesting to see what long-term difference to the colorectal cancer rate aspirin makes. Furthermore, the authors state, 'because the study was stopped early, the magnitude of the effect of aspirin may have been exaggerated'. The authors also recommend that the risks and benefits of other agents with better safety profiles should be compared with aspirin, before aspirin is routinely recommended in this situation. (See 23-195)

23-195 A randomized trial of aspirin to prevent colorectal adenomas.

Baron JA, Cole BF, Sandler RS, et al. N Engl J Med. 6 March 2003. Vol.348. No.10. p.891-99.
Reviewed by Dr Raina Elley
Review: This double blind randomised controlled trial differs from the previous study (see 23-194) in that 1 121 patients with previous adenomas were randomised to receive placebo, 81mg of aspirin, or 325mg of aspirin, and followed for approximately three years. In contrast to the previous study, the group taking the 325mg of aspirin did not have statistically significant reductions in the incidence of one or more adenomas when compared with placebo (RR 0.83 95% CI 0.55 to 1.23), but the group taking 81mg did have reduced incidence (RR 0.59 95% CI 0.38 to 0.92). The authors did not know why the lower dose of aspirin was more effective than the higher dose, particularly in the light of the results of the previous study.
Comment: These results are interesting. The lower doses of aspirin would be associated with lower rates of side effects than if 325mg was required, which is an advantage. However, as some of the issues are not understood, such as the seemingly inconsistent results with aspirin dose when compared with the previous study, it is probably a little early to routinely recommend low-dose aspirin for patients with previously diagnosed adenomas.

Oral Health

23-196 Burning mouth syndrome.

Grushka M, Epstein JB, Gorsky M. Am Fam Physician. 15 February 2002. Vol.65. No.4. p.615-20.
Reviewed by Dr J Corbett
Review: BMS is characterised by burning sensation in the tongue and other oral sites and is often associated with dryness and taste alterations. Etiological factors are discussed and the medical management outlined, including use of capsaicin.
Comment: Useful patient handout is included. Gives a good grasp of the problem, here is yet another condition to respond to low dose amitriptyline.

Paediatrics

23-197 The newborn examination: Part I. Emergencies and common abnormalities involving the skin, head, neck, chest, and respiratory and cardiovascular systems.

Fuloria M, Kreiter S. Am Fam Physician. 1 January 2002. Vol.65. No.1. p.61-8.
Reviewed by Dr J Corbett
Review: Emergencies and common abnormalities involving the skin, head, neck, chest, and respiratory and cardiovascular systems. (Does not include treatment and diagnosis of cutaneous vascular lesions).
Comment: Directed at newborn examination. Some useful diagrams to aid with diagnosis. There are many disorders we will never now see, if in doubt - refer on! Moderately useful only. (Part II – see 23-198.)

23-198 The newborn examination: Part II. Emergencies and common

abnormalities involving the abdomen, pelvis, extremities, genitalia, and spine.

Fuloria M, Kreiter S. Am Fam Physician. 15 January 2002. Vol.65. No.2. p.265-70.

Reviewed by Dr J Corbett

Review: Emergencies and common abnormalities involving the abdomen, pelvis, extremities, genitalia, and spine.

Comment: Reminds us that if one anatomic malformation is present, this should alert us to look for others. Moderately useful pointers and tables for differential diagnoses. (Part I – see 23-197.)

Pharmacology

23-199 Anticoagulation in hospitals and general practice.

Blann AD, Fitzmaurice DA, Lip GY. BMJ. 18 January 2003. Vol.326. No.7381. p.153-6.

Reviewed by Dr Len Brake

Review: One of the ABC group of articles. This is an excellent summary of the now widespread use of warfarin. Usually this is started in hospital and the maintenance is managed in the general practice of the patient. Almost any drug can interact with warfarin – paracetamol increasing the anticoagulant effect as an example.

Comment: An educational update.

Physician-Patient Relations

23-200 Should visit length be used as a quality indicator in primary care?

Druss B, Mechanic D. Lancet. 5 March 2003. Vol.361. No.9364. p.1148.

Reviewed by Dr Tony Hanne

Review: This commentary was provoked by a British study which suggested that length of consultation was a useful measure of quality. The writers object that this is not necessarily so depending on how well the extra time is used. They point out that dealing with the modern patient's extra demands because of Internet information, or the greater expectations of health systems for screening, reporting and education all extend the time needed before coming to the actual reason for the visit. The real issue they say is how well the time available is spent.

Comment: The article is worth reading because of the questions it provokes about quality and its measurement but it is a comparison of apples with oranges. The British researchers are describing a system where 10 minutes is a 'long' consultation. The US commentators see an average consultation as about 20 minutes. Perhaps the question needs to be turned around the other way. Can an average of five to seven minutes for a consultation be consistent with good quality care?

Practice Management

23-201 Advanced access: Reducing waiting and delays in primary care.

Murray M, Berwick DM. JAMA. 26 February 2003. Vol.289. No.8. p.1035-40.

Reviewed by Dr Raina Elley

Review: This article offers the rationale behind the 'advanced access' (also known as same-day scheduling) approach to reducing waiting and delays in general practice by matching supply and demand on a daily basis ('doing today's work today'). The approach is based on queuing theory and is designed to make better use of clinical resources, and produce more satisfied patients, less stressed staff and higher levels of timeliness and clinical continuity. It is suitable for small and large practices and does not require extra resources. There are six elements of advanced access. These include balancing the flow of supply and demand, a one-off reduction of backlog, and reducing the variety of appointment types. The other elements include having contingency plans in place for increased demand or reduced personnel availability, reducing and shaping the demand for visits, and identifying bottlenecks so they can be minimised by rearranging and delegating tasks.

Comment: Although this principle was developed in the US, there are some useful strategies worth examining for New Zealand primary care. An accompanying article by M Murray et al. (see 23-202), in the same edition, identified 85 primary care practices that had implemented advanced access. Examples of practices that had successfully, and unsuccessfully, implemented the model are discussed, which may offer some helpful tips.

23-202 Improving timely access to primary care: Case studies of the advanced access model.

Murray M, Bodenheimer T, Rittenhouse D, et al. JAMA. 26 February 2003. Vol.289. No.8. p.1042-6.

Reviewed by Dr Raina Elley

Review: See 23-201.

Preventive Medicine and Screening

23-203 DEET is the most effective mosquito repellent.

Margo KL. J Fam Pract. October 2002. Vol.51. No.10. p.822.

Reviewed by Dr Bruce Adlam

Review: DEET is clear winner. Soybean oil repellant are similar to lowest concentrations of DEET (about 90 minutes). Impregnated wrist bands are not effective. Citronella based lotion worked for only 10 minutes at best. Citronella candles are not much better than ordinary candles and are effective only when the user is near the candle. (Original article reviewed: N Engl J Med 2002; 347: 13-8)

Comment: Limit DEET concentration to 10% in children. Study protection duration was five hours, probably less in the field.

23-204 Improving influenza vaccination rates in the elderly.

Birchmeier M, Favrat B, Pecoud A ,et al. J Fam Pract. October 2002. Vol.51. No.10. p.856 abstract (full article online)

Reviewed by Dr Bruce Adlam

Review: The systematic intervention of a health care professional recommending vaccination before a visit

to the doctor is an effective measure to achieve high coverage.

Primary Health Care

23-205 Primary care in the United States: Organisation of primary care in the United States.

Bindman AB, Majeed A. BMJ. 22 March 2003. Vol.326. No.7390. p.631-4.
Reviewed by Dr Len Brake

Review: Articles dealing with GP organisations are to be inspected closely. Primary care is undergoing dramatic changes in the UK, USA and in NZ. Models of care that are appropriate for one culture do not necessarily suit another. The term 'GP' means a doctor who did not complete a specialist residency in the US, and they often have hospital roles. See 'hospitalist'. General physicians and paediatricians on the other hand, mostly work in offices in the community. With the days of the traditional New Zealand GP declining, what other options are there?

23-206 Is primary-care research a lost cause?

The Lancet. Lancet. 22 March 2003. Vol.361. No.9362. p.977.
Reviewed by Dr Tony Hanne

Review: A recent WONCA conference was held in Canada on research in family medicine. This commentary suggests that there was so much emphasis on defining the unique jargon and methods of general practice research that little solid research was actually presented. The writer questions the value of trying to fence off and protect GP research as some mystical activity apart from the rest of medicine.

Comment: This criticism was sparked by a series of articles in the Annals of Internal Medicine questioning the future of primary care as a discipline which has lost its way and seeing the failure of family medicine research as evidence of this. There are huge numbers of good questions waiting to be well answered from within the rich data of general practice. What stops us exploring them is worth debating.

Procedures and Techniques

23-207 Diagnostic and therapeutic injection of the shoulder region.

Tallia AF, Cardone DA. Am Fam Physician. 15 March 2003. Vol.67. No.6. p.1271-8.
Reviewed by Dr Len Brake

Review: This article is one of a series of 'Office procedures' and I take this opportunity of giving the web address for this journal (http://www.aafp.org/afp.xml). The articles are all GP orientated and many have pdf downloads available. This shoulder injection update is now copied to our office reference library and is already well thumbed. The text is very practical and is clearly written by clinicians at the coalface. (It is best to get these articles from the internet as the colour photographs print well.)

23-208 Hair apposition technique is better than suturing scalp lacerations.

Weick R, Stevermer JJ. J Fam Pract. October 2002. Vol.51. No.10. p.818.
Reviewed by Dr Bruce Adlam

Review: After cleaning the wound and without anaesthesia about four to five hairs from each side are twisted together and a drop of tissue adhesive is placed on the twist to hold it in place. A series of twists are placed over the wound to appose the wound. Patients are advised not to wash their hair for two days. (Original article reviewed: Ann Emerg Med 2002; 40:19-26)

Comment: It's faster, better tolerated and there is less scarring in these 189 patients with linear non stellate wounds less than 10 cm in length.

Psychiatry and Psychology

23-209 Why do psychiatric drug research in children?

Wiznitzer M, Findling RL. Lancet. 5 April 2003. Vol.361. No.9364. p.1147-8.
Reviewed by Dr Tony Hanne

Review: Children are not little adults even though society increasingly seems to regard them as so. This maxim is also true of their brains in which physiology and biochemistry are in various stages of maturation. Psychopharmacology cannot be assumed to need only scaling doses down for size. Far too little research is being done on the unique effects of psychotropic drugs on children. Far too much reliance is being placed on drug use as the only way to help children.

Comment: Not only is there often an inadequate evidence base for drug treatment in children with psychiatric conditions but the same can be said for non-drug treatment. These children are often at the centre of competing claims by various clinical disciplines, by drug companies, by social workers, and by educationalists. Parents often feel excluded. Informed consent by children for treatment or research is of dubious quality.

23-210 Primary care and victims of domestic violence.

Yeager K, Seid A. Prim Care. March 2002. Vol.29. No.1. p.125-50.
Reviewed by Dr M Hewitt

Review: An overview about how best to manage a difficult yet increasingly more common situation for primary care providers. Empathy and appropriately trained primary care physicians with the skills needed to treat the plethora of mental and psychological dysfunction commonly associated with domestic violence, are needed.

Comment: There is a clear need for updating or acquiring the necessary mentioned skills for primary care physicians to be able to offer meaningful assistance for this distressed group of people.

23-211 Review: screening for depression reduces persistent depression.

Sherman SE. Evidence-Based Medicine. November/December 2002. Vol.7. No.6. p.178.
Reviewed by Dr Bruce Arroll

Review: This paper was a summary of the new guidelines from the US task force. They have changed their mind and now support the use of routine screening in primary care. (Original article reviewed: Ann Intern Med 2002 May 21; 136: 765-76)
Comment: The commentator makes the point that the screening and feedback to the physician increases the detection of depression. The other comment was that care needs to be reorganised so that there is a structure to deal with depressed patients. He suggested the use of a care manager to assist the practices with the management of depression (i.e. to make phone calls to check on compliance).

Respiratory System

23-212 Chronic cough.

Currie GP, Gray RD, McKay J. BMJ. 1 February 2003. Vol.326. No.7383. p.261.
Reviewed by Dr Len Brake
Review: This is one of a series of one-page articles on common problems in primary care. An ongoing cough in children is frustrating to parents especially if the cough persists throughout the night. Often, antibiotics and the desultory use of an 'inhaler' has been tried with no effect, time has gone by and the gauntlet is thrown down - 'fix this!'
Comment: Issues to cover and appropriate tests are outlined here as well as useful reading. These summaries are easy to print from the BMJ site.

Rheumatic Diseases

23-213 Arthroscopic surgery ineffective for osteoarthritis of the knee.

Bailey RE. J Fam Pract. October 2002. Vol.51. No.10. p.813.
Reviewed by Dr Bruce Adlam
Review: Uncontrolled studies show that up to half of patients with OA receive pain relief from this procedure. Pain relief is not due to the arthroscopy, suggests this double blind RCT. Arthroscopy with and without debridement of any debris does not provide any benefit over 'sham surgery' in reducing pain symptoms or physical functioning. (Original article reviewed: N Engl J Med 2002; 347: 81-8)
Comment: Both probably had a placebo effect although an expensive and potentially hazardous one.

Sports and Sports Medicine

23-214 Computerised neuropsychological testing.

Collie A, Maruff P. Br J Sports Med. 1 February 2003. Vol.37. No.1. p.2-3.
Reviewed by Dr Chris Milne
Review: In the past five years, computerised neuropsychological testing has come of age. It is now part of routine clinical practice for those of us who assess professional athletes who have been concussed. The two authors, who have been instrumental in developing the CogState battery of tests, argue (correctly in my view) that it is appropriate for team doctors to interpret the results of such tests without recourse to a neuropsychologist.
Comment: I would support their view, especially as there is a relative shortage of qualified neuropsychologists in New Zealand who are available to perform these tests at short notice. It goes without saying that a preseason baseline test is required, but I'll say it anyway!

23-215 Risk factors for lower extremity injury: a review of the literature.

Murphy DF, Connolly DA, Beynnon BD. Br J Sports Med. 1 February 2003. Vol.37. No.1. p.13-29.
Reviewed by Dr Chris Milne
Review: Following an extensive literature review, these authors conclude that the injury risk is greater in competition than training sessions, on artificial turf compared with grass or gravel, and that previous injury when coupled with inadequate rehabilitation is a risk factor for subsequent injury. Bracing or taping may reduce the risk of ankle injury, especially in athletes with a previous ankle injury.
Comment: This is a comprehensive (18 page) article with 87 references. It represents the best evidence-based advice we have on this important topic.

23-216 Diving medicine: A comprehensive review.

Fotopolous CL, Lynott J, Mole J et al. Patient Care. 30 June 2000. Vol.34. No.12. p.20-54.
Reviewed by Dr Len Brake
Review: Waffle-free and up to date. This is an excellent review for the GP assessing the eligibility of a potential diver. I found this article when looking for advice on whether a history of asthma is a contraindication to diving.
Comment: Recommended for the Practice bookshelf.

23-217 Swimming biomechanics and injury prevention: New stroke techniques and medical considerations.

Johnson JN, Gauvin J, Fredericson M. Physician and Sportsmedicine. January 2003. Vol.31. No.1. p.41-6.
Reviewed by Dr Rob Campbell
Review: A review of biomechanics of swimming revealing that its understanding has changed over the last 10 years. The training of correct biomechanics and strength training to prevent injury has also advanced. Also attached is a patient handout of preventive exercises.
Comment: For a virtual non swimmer like myself this paper is fantastic and I hope all those who swim or have swimming children read it and give a copy to the coach who probably knows it all!

23-218 Preventing infectious diseases in sports.

Howe WB. Physician and Sportsmedicine. February 2003. Vol.31. No.2. p.23-9.
Reviewed by Dr Rob Campbell
Review: This paper reviews the problem of infectious diseases in sport, some basic hygiene practices and then methods to increase immunity. The vaccination programme is described for USA and the preventive use of antivirals is not common practice in NZ.

Comment: A practical paper with good advice on prevention. If you are looking after a team or a school it is worth reading.

Travel Medicine

23-219 Doxycycline induced intracranial hypertension.

Lochhead J, Elston JS. BMJ. 22 March 2003. Vol.326. No.7390. p.641-2.
Reviewed by Dr Len Brake

Review: Doxycycline is being increasingly used as malaria prophylaxis often over considerable time periods. This is a report of two cases with the side effect of intracranial hypertension induced from doxycycline. Previous reports had associated this clinical problem with long-term use of minocycline for acne.
Comment: Both cases described did well after the medication was stopped despite the intensive medical investigations!

23-220 Pre-travel advice: an overview.

Sanford C. Prim Care. December 2002. Vol.29. No.4. p.767-785.
Reviewed by Dr M Hewitt

Review: The article gives considerations to the anticipated problems and risk of travel and how they can be minimised or eliminated.

23-221 Immunizations for international travel.

Thompson MJ. Prim Care. December 2002. Vol.29. No.4. p.787-814.
Reviewed by Dr M Hewitt

Review: An assessment prior to travel to 'at-risk' areas of the world involves immunisation as an important form of health care disease prevention. The common as well as rare vaccinatable diseases are discussed, with emphasis on indications, contraindications and side effects.
Comment: Useful review.

23-222 The prevention of malaria.

Magill AJ. Prim Care. December 2002. Vol.29. No.4. p.815-42.
Reviewed by Dr M Hewitt

Review: Prevention involves eradication of the mosquito and minimising optimum facilities for breeding of the species. Other practical options, many of which are old fashioned, but none the less effective, include netting.
Comment: Common sense.

23-223 Prevention and self-treatment of travelers' diarrhea.

Diemert DJ. Prim Care. December 2002. Vol.29. No.4. p.843-55.
Reviewed by Dr M Hewitt

Review: Prevention will help to minimise risk. The disease is self limiting and the author recommends a combination of oral antibiotic and antimotility agents.
Comment: This is not what Dr Ellis-Pegler of the Infections Diseases Department of Auckland Hospital recommends. It is advisable not to take antimotility agents for the risk of retention of infective material and paralytic ileus. Better to maintain hydration and electrolyte balance.

23-224 Intestinal parasites.

Jong E. Prim Care. December 2002. Vol.29. No.4. p.857-77.
Reviewed by Dr M Hewitt

Review: Knowledge of the local environment the traveller will encounter will determine if prevention as well as treatment will be necessary. Traveller's intentions and activities will reveal risks.

23-225 Screening of international immigrants, refugees, and adoptees.

Stauffer WM, Kamat D, Walker PF. Prim Care. December 2002. Vol.29. No.4. p.879-905.
Reviewed by Dr M Hewitt

Review: The article covers the current requirements for refugee evaluation by the International Office of Migration. The health care providers conduct screening according to current CDC and Prevention guidelines. Routine tests include chest x-ray, VDRL/RPR for syphilis and HIV testing. Health interventions include immunisations and empiric anthelminthics.
Comment: Similar to New Zealand with the exception of routine HIV testing. I feel this is a matter that should be reviewed so that New Zealand is in line with other countries screening policies.

23-226 Zoonotic infections in travelers to the tropics.

Sellman J, Bender J. Prim Care. December 2002. Vol.29. No.4. p.907-29.
Reviewed by Dr M Hewitt

Review: Assessment prior to travel will help to identify and eliminate risks. Types of zoonotic agents are mentioned by pathogen type, such as those which are vector borne, arthropods and micro-organisms. Some descriptions of the haemorrhagic fevers and common bacterial agents are given, along with lice, typhus, plague and Q fever.
Comment: Mainly rats and mice excreta to avoid for the haemorrhagic fevers.

23-227 Evaluation of diarrhea in the returned traveler.

Kolars JC, Fischer PR. Prim Care. December 2002. Vol.29. No.4. p.931-45.
Reviewed by Dr M Hewitt

Review: Consideration of the history and examination provides the most information prior to requesting laboratory assistance. The list is long, depending on the chronicity and the likely diagnosis.
Comment: A useful list of all the likely possibilities. A helpful summary.

23-228 Evaluation of fever in the returned traveler.

McLellan SL. Prim Care. December 2002. Vol.29. No.4. p.947-69.
Reviewed by Dr M Hewitt

Review: History of the condition along with the likely incubation increases the likelihood of diagnosis. Of note are the common mundane diagnoses which also feature along with exotic causes of fever in the returned traveller. The exposures include consumption of water and food, and vectors such as insects and microbes. Human are also involved with sexual contact. Group travel and fresh water swimming are other examples of significant exposures.

Comment: After the exposure comes the condition. The fever is a marker and in some cases, a diagnostic feature.

23-229 Skin diseases of travelers.

Joyce MP. Prim Care. December 2002. Vol.29. No.4. p.971-81.
Reviewed by Dr M Hewitt

Review: Skin rashes are a common presentation after travel for primary care physicians. These range from the common to the exotic and obscure. As with all skin conditions a good history to identify the exposure and a good description based on the physical examination are key features in successful diagnosis.
Comment: An extensive list covers most of the known exotic skin conditions.

23-230 The adolescent traveler.

Breuner CC. Prim Care. December 2002. Vol.29. No.4. p.983-1006.
Reviewed by Dr M Hewitt

Review: The advice is more for the known maladaptive behaviour of adolescents rather than travel itself. STDs, nutrition and illicit drug use are greater problems due to unsupervised risk taking. HEADSS for a complete history and pre-travel assessment of morbid personality factors may be more useful in preventing problems than vaccines and travel medicine.
Comment: It is high risk to let an adolescent loose overseas without adequate adult/parent supervision.

Urology

23-231 Saw palmetto for prostate disorders.

Gordon AE, Shaughnessy AF. Am Fam Physician. 15 March 2003. Vol.67. No.6. p.1281-3.
Reviewed by Dr Len Brake

Review: This is a herbal product from the fruit of the American dwarf palm tree. It is used to treat BPH and this article has all references available. There is evidence that its efficacy is similar to available medication with less side effects. To date there are no data on long-term side effects.
Comment: A helpful and concise summary though.

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