Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed In this Issue

Acta Anaesthesiol Scand*
Am J Clin Nutr *
Ann Emerg Med*
Ann Intern Med*
ANZ J Surg*
Aust Fam Physician*
Br J Sports Med*
Brain Res Bull*
Can Fam Physician Med Fam Can*
Dermatol Ther*
Evidence-Based Medicine*
J Altern Complement Med*
J Fam Pract*
J Urol*
JAMA*
Lancet*
Physician and Sportsmedicine*
Postgrad Med*
Urology*
*Journals indexed in Medline

Acupuncture

24–162 Acupuncture ameliorates symptoms in men with chronic prostatitis/chronic pelvic pain syndrome.

Chen R, Nickel JC. Urology. June 2003. Vol.61. No.6. p.1156–9.
Reviewed by Dr Alex Chan

Review: A pilot uncontrolled study on the use of acupuncture, using three sets of acupoint prescriptions, in 12 patients with chronic prostatitis/chronic pelvic pain syndrome refractory to standard therapy. Patients treated twice weekly for six weeks and followed up to an average of six months. There was significant reduction in the average NIH Chronic Prostatitis Symptom Index total score, as well as in the separate domains of pain, urinary and quality-of-life scores immediately after completion of the course of acupuncture and the effects persisted at six months.

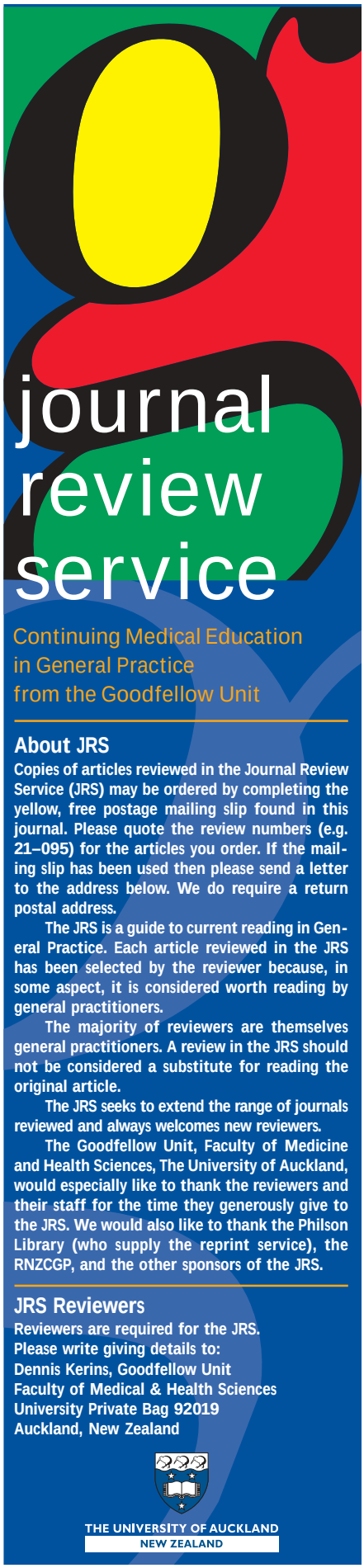
Comment: The first set of acupoints utilised the concept of divergent meridian, but the second and third sets were local points and acupoints that influence the local sympathetic and pelvic plexus and L4, L5, S1 and S2 nerve segments. Contrast this study to that of Johnstone et al. (2003) which only used the Kidney-Bladder distinct meridian protocol alone (See 24–163).

24–163 A prospective, randomized pilot trial of acupuncture of the kidney-bladder distinct meridian for lower urinary tract symptoms.

Johnstone PA, Bloom TL, Niemtzow RC, et al. J Urol. March 2003. Vol.169. No.3. p.1037–9.
Reviewed by Dr Alex Chan

Review: 30 patients with benign prostatic hypertrophy and lower urinary tract symptoms were randomised to the trial, which had three arms – (1) non-treatment group, (2) acupuncture group, and (3) sham acupuncture group. The Kidney-Bladder distinct meridian protocol was used and acupuncture was given three times weekly for the first two weeks and then once weekly during weeks three, four, and eight. Patients were assessed using the International Prostate Symptom Score and PSA. There were no significant differences among the randomised arms in those scores over a three month period.

Comment: Contrast this study to that of Chen and Nickel (2003) (see 24–162) in which local acupoints and other neurologically active acupoints were used. It is possible that use of the distinct meridian protocol alone may not be sufficient to influence the organs that they pass through.



24–164 The use of electro-acupuncture in conjuction with exercise for the treatment of chronic low-back pain.

Yeung CK, Leung MC, Chow DH. J Altern Complement Med. August 2003. Vol.9. No.4. p.479–90.
Reviewed by Dr Alex Chan

Review: A randomised controlled study of the effects of electro-acupuncture (EA) plus exercise versus exercise alone in 52 patients with non-specific chronic low back (LBP) pain without any underlying pathophysiologic or anatomic problems. EA was administered three times per week for four weeks to BL23, 25, 40, SP6 acupoints unilaterally on the symptomatic side. Assessment by a blinded observer showed significantly better scores in Numerical Rating Scale for pain, and Aberdeen LBP scale for disability immediately after treatment, at one month and at three months follow-up. However, there was no significant change in lumbar spine active range of movement or isokinetic strength.
Comment: A well conducted study though there was no control for the possible placebo effects from acupuncture. This raises the question whether it is Patient-Oriented Evidence that Matters (POEM) or a therapeutic regime that has to be trialled by the golden standard of triple blinded randomised controlled study (triple blinded RCT) before it can be considered acceptable.

24–165 Acupuncture, electrostimulation, and reflex therapy in dermatology.

Chen CJ, Yu HS. Dermatol Ther. 2003. Vol.16. No.2. p.87–92.
Reviewed by Dr Alex Chan

Review: A review article on the use of acupuncture in acne, herpes zoster, psoriasis, atopic eczema, and urticaria. The cutaneous needle (also known as plum blossom needle) was particularly mentioned for its special role in the treatment of chronic refractory skin diseases such as psoriasis, neurodermatitis, and atopic eczema. According to the authors, acne requires 20–24 acupuncture treatments.
Comment: Useful reference article from a western trained physician and a dermatologist.

24–166 Enhancement of electroacupuncture-induced analgesic effect in cholecystokinin-A receptor deficient rats.

Lee GS, Han JB, Shin MK, et al. Brain Res Bull. 15 December 2003. Vol.62. No.2. p.161–4.
Reviewed by Dr Alex Chan

Review: The relationship between CCK receptors expression and electroacupuncture (EA)-mediated analgesic effects in specially bred CCK–A receptor knockout rats was examined in this study in comparison to normal rats. Two Hz EA was applied to the acupoint ST–36 for 15 minutes. Tail flick latency (TFL) test was used to quantify analgesic effects and the mean percentage increase in TFL from baseline was calculated. EA significantly delayed the TFL response in both groups and significantly more so in the CCK deficient rats than the normal rats.
Comment: One of the possible mechanisms in EA non-responder (low effect) to analgesia is an increased release of cholecystokinin (CCK)–8 in the central nervous system. This study only examined the effects of CCK–A deficiency. Experimentally, CCK–B receptor antagonists have been used to revert non-responders to responders.

24–167 Acupuncture anaesthesia in inguinal hernia repair.

Chu DW, Lee DT-Y, Chan TT-F, et al. ANZ J Surg. May 2003. Vol.73. No.3. p.125–7.
Reviewed by Dr Alex Chan

Review: 12 patients had their inguinal hernia repair under four Hz electro-acupuncture anaesthesia. After premedication with pethidine and diazepam, the acupoints ST–36, SP–6, GB27, GB–28, KI–13, KI–14 were needled and stimulated, together with the insertion of two three cm long paraincisional needles along the planned incision site. The induction time of anaesthesia was 15 minutes after which all the needles except ST–36 and SP–6 were removed. The median highest pain score during the operation was 2.25 out of 10. The mean volume of local lignocaine required was 1.4 ml (compared with 100–150 ml in patients who only have local lignocaine for similar operations).
Comment: Note that all patients noticed pain four to six hours after the operation and required a few tablets of dextropropoxyphene for analgesia after that. Not a double-blind trial, but nine patients commented they had good anaesthetic effects and three patients had satisfactory anaesthetic effects during the surgical procedure.

24–168 Acupuncture fails to reduce but increases anaesthetic gas required to prevent movement in response to surgical incision.

Kvorning N, Christiansson C, Beskow A, et al. Acta Anaesthesiol Scand. August 2003.

Vol.47. No.7. p.818–22.
Reviewed by Dr Alex Chan
Review: This double-blind randomised controlled study compared the analgesic effects of two Hz electroacupuncture (EA) with sham procedure in 46 healthy women who underwent laparoscopic sterilisation under general anaesthesia. The interventions were performed for 25 minutes after induction of anaesthesia. The assessment endpoint was the minimal alveolar concentration of sevoflurane (an anaesthetic agent) required to prevent neck or major limb movements on surgical incision. The acupoints used were LI–4, PC–6, ST–36, SP–9, SP–6 and LR–3. Interestingly, EA was found to increase the clinical need for anaesthetic gas.
Comment: Controversies exist on the analgesic effects of acupuncture on anaesthetised patients. It is worthwhile to be aware of this.

24–169 Acupuncture facilitates neuromuscular and oculomotor responses to skin incision with no influence on auditory evoked potentials under sevoflurane anaesthesia.

Kvorning N, Christiansson C, Akeson J. Acta Anaesthesiol Scand. October 2003. Vol.47. No.9. p.1073–8.
Reviewed by Dr Alex Chan
Review: Effects of two Hz electroacupuncture (EA) versus sham procedure were observed in 45 patients under steady state anaesthesia with sevoflurane for laparoscopic sterilisation. In addition to increased movement of the neck or limbs, there was significantly higher incidence of dilatation of the pupils, and divergence of the eye axes in the acupuncture than in the sham procedure patients. There was no significant differences in the responses of the mean arterial pressure and heart rate to skin incision between the two groups. There was also no difference in middle latency auditory evoked potential activity which correlates with the depth of anaesthesia. Therefore, the mechanism which facilitated the neuromuscular and oculomotor responses to nociceptive skin stimulation under sevoflurane anaesthesia did not appear to include the depth of the anaesthesia.
Comment: The study raises the possibility of EA facilitating nociception when performed after induction of anaesthesia.

Alcohol and Substance Abuse

24–170 Screening and intervention for excessive drinking produce small results.

Via RM. J Fam Pract. January 2003. Vol.53. No.1. p.15–6.
Reviewed by Dr Bruce Adlam
Review: Practice Recommendations – it is reasonable to consider screening for excessive alcohol consumption if time and circumstances permit, realising the ultimate benefit will be extremely small. Overall, if a practitioner screens 1000 patients, carries out further assessment in 90 (nine per cent) who screen positive, and gives feedback, information, and advice to the 25 (2.5%) who qualify for brief intervention, two or three patients can be expected to have reduced their alcohol consumption to below recommended maximum levels after 12 months. This results in a number needed to screen with outcome measured at one year of 500. (Original article reviewed: BMJ 2003; 327:536–540)
Comment: The number needed to screen in dyslipidaemia to prevent one death in five years is 418 and mammography 2451.

Asthma

24–171 Review: Long acting beta2 agonists are better than short acting beta2 agonists in chronic asthma.

Golish JA. Evidence-Based Medicine. September/October 2003. Vol.8. No.5. p.145.
Reviewed by Dr Bruce Arroll
Review: Long acting beta agonists are better than short acting beta agonists in chronic asthma. Originally a Cochrane review, this review found a benefit for long acting beta agonists over short acting beta agonists, at least in terms of lung function and the need for rescue bronchodilator. (Original article reviewed: Cochrane Database Syst Rev 2002; (4):CD003901)
Comment: The commentator suggests that long acting beta agonists are still third line treatment and that we should not ignore inhaled corticosteroids.

24–172 Impermeable bed covers ineffective for asthma.

Young C, Chambliss L. J Fam Pract. November 2003. Vol.52. No.11. p.837–8.
Reviewed by Dr Bruce Adlam
Review: Allergen-impermeable bed covers, as a single intervention, are ineffective for the management of asthma symptoms in adults. They are also ineffective for patients with allergic rhinitis. (Original article reviewed: N Engl J Med 2003; 349:225–36.)

Cardiovascular System

24–173 No pain, no gain? Thoughts on the Caerphilly study.

Lee I-M. Br J Sports Med. 1 February 2004. Vol.38. No.1. p.4–5.
Reviewed by Dr Chris Milne
Review: The Caerphilly study considered the question of how intensively one needs to exercise to reduce cardiovascular disease mortality. It concluded that only heavy or vigorous exercise was independently associated with reduced risk of premature death from cardiovascular disease. This is at odds with the current dogma dating from US Surgeon-Generals report in 1995 which recommended only moderate intensity physical exercise.
Comment: On how the pendulum swings! The bottom line in my view is that in today's epidemic of fat people, any exercise is better than none. Let's not get too hung up on the minutiae.

24–174 Adjunctive treatment with eplerenone reduced morbidity and mortality in acute myocardial infarction.

Prabhakar M, Massel D. Evidence-Based Medicine. September/October 2003. Vol.8. No.5. p.146.
Reviewed by Dr Bruce Arroll
Review: Adjunctive treatment with eplerenone reduced morbidity and mortality in acute myocardial infarc-

tion. This review found a benefit for this selective aldosterone blocker (similar to spironolactone) in patients with LV dysfunction after acute MI. The NNT for death from any cause was 44. (Original article reviewed: N Engl J Med 2003; 348:1309–21.)
Comment: The commentator suggests giving aldosterone blockers to all patients with clinical LV dysfunction after MI.

24–175 Patients with acute MI should be transferred for angioplasty.

Fitzsimmons A, Lindbloom EJ. J Fam Pract. December 2003. Vol.52. No.12. p.940–1.
Reviewed by Dr Bruce Adlam
Review: Angioplasty within two hours of presentation for acute myocardial infarction (MI) is superior to thrombolysis, primarily due to a lower reinfarction rate. This is true whether a patient presents to a healthcare facility with angioplasty capability or one that transfers a patient. In this study Danish researchers enrolled 1572 adult patients diagnosed with acute MI, and studied 30 day outcomes against the treatment options. (Original article reviewed: N Engl J Med 2003; 349: 733–742.)

24–176 Preventing VTE in hospitalized patients.

Holten KB. J Fam Pract. January 2004. Vol.53. No.1. p.38–40.
Reviewed by Dr Bruce Adlam
Review: This good concise item that answers the following questions: 1. How do we determine risk of venous thromboembolism (VTE) in patients scheduled for surgery? 2. Do all surgical patients require VTE prevention? 3. Is aspirin adequate to prevent VTE in low-risk hospitalised patients? 4. Which anticoagulant is appropriate for a patient scheduled for total knee replacement? These important questions are answered in a guideline developed by a committee of the American College of Chest Physicians, which considered the following prophylaxis recommendations: early ambulation, aspirin, graduated compression stockings, intermittent pneumatic compression, low-dose unfractionated heparin, low-molecular-weight heparin, or oral antithrombotic agents.
Comment: Good value.

Cerebrovascular System

24–177 Effects of cholesterol-lowering with simvastatin on stroke and other major vascular events in 20–536 people with cerebrovascular disease or other high-risk conditions.

Heart Protection Study Collaborative Group. Lancet. 6 March 2004. Vol.363. No.9411. p.757–67.
Reviewed by Dr Tony Hanne
Review: Over 20 000 patients at high risk of vascular events because of past history or of diabetes were randomised to simvastatin 40mg daily or placebo and followed for five years. The risk of ischaemic stroke was reduced by about a quarter in the treated group regardless of age or pre-treatment cholesterol levels.
Comment: The reduction of coronary artery disease had previously been clearly demonstrated but the issue of benefit in risk of future stroke was uncertain. By studying larger numbers with pre-existing disease a clear benefit became obvious. Our traditional approach of not treating older patients or anyone with an average level of cholesterol with lipid-lowering drugs was clearly wrong.

Communicable Diseases, Infections and Parasites

24–178 SARS: a new infectious disease for a new century.

Whitby N, Whitby M. Aust Fam Physician. October 2003. Vol.32. No.10. p.779–83.
Reviewed by Dr Barry Suckling
Review: An excellent overview of the epidemic of severe acute respiratory syndrome (SARS).

24–179 Cytomegalovirus: a common virus causing serious disease.

Rawlinson W, Scott G. Aust Fam Physician. October 2003. Vol.32. No.10. p.789–93.
Reviewed by Dr Barry Suckling
Review: A clear guide to diagnosis and treatment of CMV in at risk patients.

24–180 Hepatitis C: an update: hepatitis C and general practice: the challenge continues.

Kidd M. Aust Fam Physician. October 2003. Vol.32. No.10. p.795.
Reviewed by Dr Barry Suckling
Review: A brilliant in-depth review of Hepatitis C. This presentation on 'Hepatitis C: an update' is divided into eight chapters, a total of 38 pages, and is the best in-depth review of the subject that I have seen.
Comment: If you only request articles on one topic this year, make it this one (see also 24–181 to 24–188 – these articles complete the set of eight chapters published in this issue of Aust Fam Physician). Editors note: A more extensive version is available as a downloadable pdf (Acrobat file) through this link (http://www.racgp. org.au/folder.asp?id=292). The online version has additional chapters on Hepatitis C and:– (a) cirrhosis and liver cancer, (b) meaning for the person, (c) meaning for the community, (d) migrants – issues for GPs and, (e) test technology.

24–181 Hepatitis C: an update: epidemiology of hepatitis C virus infection in Australia.

Dore GJ, MacDonald M, Law MG, et al. Aust Fam Physician. October 2003. Vol.32. No.10. p.796–8.
Reviewed by Dr Barry Suckling
Review: See 24–180.

24–182 Hepatitis C: an update: preventing transmission of hepatitis C.

MacDonald J, Wodak A. Aust Fam Physician. October 2003. Vol.32. No.10. p.799–803.
Reviewed by Dr Barry Suckling
Review: See 24–180.

24–183 Hepatitis C: an update: acutehepatitis C.

Marinos G, Post J. Aust Fam Physician. October 2003. Vol.32. No.10. p.804–6.
Reviewed by Dr Barry Suckling
Review: See 24–180.

24–184 Hepatitis C: an update: chronic hepatitis C.

Batey RG. Aust Fam Physician. October 2003. Vol.32. No.10. p.807–11.
Reviewed by Dr Barry Suckling
Review: See 24–180.

24–185 Hepatitis C: an update: pretest counselling and diagnosis.
McCoy R, Watson K, Kosky M. Aust Fam Physician. October 2003. Vol.32. No.10. p.812–6.
Reviewed by Dr Barry Suckling
Review: See 24–180.

24–186 Hepatitis C: an update: post-testing counselling and initial management.
Kidd M, Cheng W, Wilson S. Aust Fam Physician. October 2003. Vol.32. No.10. p.817–9.
Reviewed by Dr Barry Suckling
Review: See 24–180.

24–187 Hepatitis C: an update: ongoing management of hepatitis C.
Harley H, Shaw D, Steven I. Aust Fam Physician. October 2003. Vol.32. No.10. p.820–5.
Reviewed by Dr Barry Suckling
Review: See 24–180.

24–188 Hepatitis C: an update: antiviral therapy for chronic hepatitis C.
Sievert W. Aust Fam Physician. October 2003. Vol.32. No.10. p.826–32.
Reviewed by Dr Barry Suckling
Review: See 24–180.

24–189 Infectious mononucleosis.
Charles PG. Aust Fam Physician. October 2003. Vol.32. No.10. p.785–8.
Reviewed by Dr Barry Suckling
Review: Presents a case of severe infectious mononucleosis, then describes the spectrum of the disease. Diagnosis and complications are reviewed, as well as management, including the possible role for antiviral medications or corticosteroid therapy.

Dermatology

24–190 Clear choices in managing epidermal tinea infections.
Thomas B. J Fam Pract. November 2003. Vol.52. No.11. p.850–62.
Reviewed by Dr Bruce Adlam
Review: Potassium hydroxide preparation should be used as an aid to diagnosis for all erythrosquamous lesions (B). Fungal culture should be used in cases in which history, physical examination, and potassium hydroxide preparation fail to clearly exclude a diagnosis of tinea (B). Short-duration topical therapy with terbinafine, naftifine, and butenafine is efficacious for most epidermal tinea infections (A). Oral antifungal agents are important in the treatment of tinea infections that are widespread, fail to respond to topical treatment, involve the thick stratum corneum of the soles and palms, or occur in immunosuppressed patients. Short courses of oral itraconazole and terbinafine are safe and effective in treating tinea infections (A).

Diagnosis

24–191 Fatigue – a general diagnostic approach.
Murtagh J. Aust Fam Physician. November 2003. Vol.32. No.11. p.873–6.
Reviewed by Dr Barry Suckling
Review: An excellent diagnostic model for the diagnosis of fatigue in general practice. Such a common problem, and a clear approach described by John Murtagh. (see also 24–192 and 24–193)

24–192 Psychological and psychiatric causes of fatigue: assessment and management.
Dick ML, Sundin J. Aust Fam Physician. November 2003. Vol.32. No.11. p.877–81.
Reviewed by Dr Barry Suckling
Review: An approach is described for the diagnosis and management of the psychological causes of fatigue. Two clinical cases are described to highlight some of the discriminating features.
Comment: A good article. (see also 24–191 and 24–193)

24–193 Chronic fatigue syndrome: the patient centred clinical method – a guide for the perplexed.
Murdoch JC. Aust Fam Physician. November 2003. Vol.32. No.11. p.883–7.
Reviewed by Dr Barry Suckling
Review: This article discusses the application of the patient centred clinical method to the diagnosis and treatment of CFS. The best hope for sufferers is self management guided by a supportive and helpful health professional. (see also 24–191 and 24–192)

Ear, Nose and Throat

24–194 Amoxicillin-clavulanate ineffective for suspected acute sinusitis.
Jackson EA. J Fam Pract. December 2003. Vol.52. No.12. p.930, 932.
Reviewed by Dr Bruce Adlam
Review: Amoxicillin-clavulanate was no more effective than placebo in quickly relieving symptoms in patients diagnosed clinically with acute sinusitis in a general practice setting. It was, however, much more likely to cause diarrhoea. (Original article reviewed: Arch Intern Med 2003; 163: 1793–8.)
Comment: Because most patients will improve spontaneously, antibiotics should be reserved for patients with prolonged symptoms. An inexpensive, narrow-spectrum drug such as amoxicillin is a good initial choice.

24–195 Tubes for otitis media do not improve developmental outcomes.
Pettinger TK, Force RW. J Fam Pract. December 2003. Vol.52. No.12. p.939–40.
Reviewed by Dr Bruce Adlam
Review: In young children with persistent otitis media with middle-ear effusions, the insertion of tympanostomy tubes does not improve cognitive, language, or speech development. (Original article reviewed: Pediatrics 2003; 112:265–77.)
Comment: The investigators conducted a randomised, double-blinded, controlled trial of 6350 infants. Authors comment that this trial was likely large enough to find a clinically significant difference if one existed.

24–196 What is the best way to manage benign paroxysmal positional vertigo?
Strickland C, Russell R. J Fam Pract. December 2003. Vol.52. No.12. p.971–3.
Reviewed by Dr Bruce Adlam
Review: A simple repositioning manoeuvre, such as the four step Epley

manoeuvre (figure shown in the article), performed by an experienced clinician, can provide symptom relief from benign paroxysmal positional vertigo (BPPV) lasting at least one month (strength of recommendation [SOR]: A). Medical therapy with benzodiazepines for vestibular suppression provides no proven benefit for BPPV (SOR: B). For undifferentiated dizziness, vestibular rehabilitation may provide symptomatic relief (SOR: B, one randomised controlled trial).

Emergency Medicine

24–197 Severely increase blood pressure in the emergency department.

Shayne PH, Pitts SR. Ann Emerg Med. April 2003. Vol.41. No.4. p.513–29.
Reviewed by Dr Mike Slatter

Review: This review article looks at the management of patients with severely increased blood pressure in the acute setting. Discusses management dilemmas, pathogenesis of hypertension and current U.S. guidelines for management of hypertension. Stratification of hypertensive crises into hypertensive emergencies, hypertensive urgencies and uncontrolled severe hypertension.
Comment: Very thorough review with good advice on management – which patients require admission and further assessment and which can be safely followed as out-patients. Looking for evidence of target organ disease is stressed. (See also 24–198.)

24–198 Hypertensive urgencies: treating the mercury?

Gallagher EJ. Ann Emerg Med. April 2003. Vol.41. No.4. p.530–1.
Reviewed by Dr Mike Slatter
Review: See 24–197.

24–199 Does acetaminophen treat fever in children?

Evered LM. Ann Emerg Med. May 2003. Vol.41. No.5. p.741–3.
Reviewed by Dr Mike Slatter
Review: This is a systematic review abstract, a regular feature of the Annals Evidence-Based Emergency Medicine Series. 12 trials met the inclusion criteria (n-1509). There was inconclusive evidence that paracetamol had a superior antipyretic effect than placebo or physical methods of cooling.
Comment: Amazingly there is a paucity of adequate research in this area. There is a useful commentary on clinical implications. Thankfully the use of paracetamol for pain and discomfort has not been challenged!

Endocrinology

24–200 Fatigue and endocrine disorders: causes and comorbidities.

Morton A, King D. Aust Fam Physician. November 2003. Vol.32. No.11. p.895–900.
Reviewed by Dr Barry Suckling
Review: Discusses the endocrine disorders that commonly present with or which develop fatigue as a prominent feature, with emphasis on particular challenges for diagnosis, investigation or management. Screening recommendations for comorbid disease is generated by an extensive review of current evidence.

24–201 Poor control of risk factors for vascular disease among adults with previously diagnosed diabetes.

Saydah SH, Fradkin J, Cowie CC. JAMA. 21 January 2004. Vol.291. No.3. p.335–42.
Reviewed by Dr Raina Elley
Review: This study compares risk and treatment characteristics of people with previously diagnosed diabetes from two US national surveys (NHANES) conducted 1988–94 and 1999–2000 (random samples but not the same individuals taking part). The results found that HbA1c and blood pressure had not improved, with less than half meeting ADA guidelines targets of <7% HbA1c (37%), <130/80mmHg blood pressure (36%), and <5.18mmol/l total cholesterol (48%) (only 7.3% reached all targets). This was despite more intensive treatment regimes being used (e.g. more on combination insulin/oral treatments, fewer on no hypoglycaemics, more on antihypertensive medications for raised blood pressure (85% compared with 77% previously), and 56% now taking medication for raised cholesterol compared with 28% previously). The minimal improvement (and some deterioration) may be explained by the increased obesity (55% now BMI >30 compared with 42% previously) and not helped by the reduction in proportion 'eating less fat' and no increase in those trying to lose weight or exercise to reduce blood pressure and cholesterol. The use of aspirin remained around 22% despite 24.5% recording a history of cardiovascular disease, and large proportions with other cardiovascular risk factors. However, people with diabetes may be living longer as the mean duration of diabetes was 12.5 years compared with 10.2 years previously (although diagnosis is also earlier now 47 years compared with 51).
Comment: There is significant evidence that improved risk factors reduces the complications and morbidity of diabetes, yet there is little improvement in management, despite evidence-based guidelines. The situation may be similar in New Zealand. More emphasis needs to be placed on systematic implementation of guidelines into practice in a pragmatic and well-planned way, with a continued emphasis on lifestyle measures as an integral part of management.

24–202 Physical activity and type 2 diabetes: tailoring exercise to optimize fitness and glycemic control.

Bhaskarabhatla KV, Birrer R. Physician and Sportsmedicine. Janaury 2004. Vol.32. No.1. p.13–7.
Reviewed by Dr Rob Campbell
Review: A review of the benefits and general types of exercise programmes but no detailed information.
Comment: A reasonable general review but very little clinical 'nous' demonstrated by the authors. Not worth more than a cursory glance.

Gastroenterology

24–203 Psychotherapy or paroxetine did not reduce

abdominal pain, but may improve quality of life in irritable bowel syndrome.

Cremonini F, Talley NJ. Evidence-Based Medicine. September/October 2003. Vol.8. No.5. p.160.

Reviewed by Dr Bruce Arroll

Review: Psychotherapy or paroxetine did not reduce abdominal pain but may improve quality of life in irritable bowel syndrome. This study found a benefit for both paroxetine and psychotherapy in patients with severe irritable bowel. There was only an improvement in quality of life and not in pain. There were problems with the study. (Original article reviewed: Gastroenterology 2003; 124:303–17.)

Comment: The commentator is cautious about these results but if all else fails this may be one parachute.

24–204 Irritable bowel syndrome: minimize testing, let symptoms guide treatment.

Holten KB. J Fam Pract. December 2003. Vol.52. No.12. p.942–50.

Reviewed by Dr Bruce Adlam

Review: Practice recommendations: (a) For patients aged <50 years without alarm symptoms, diagnostic testing is unnecessary, (b) Treatment is indicated when both the patient with irritable bowel syndrome and the physician agree that quality of life has been diminished (C), (c) The goal of therapy is to alleviate global IBS symptoms (abdominal discomfort, bloating, and altered bowel habits that are life-impacting) (C).

Comment: Agents of interest are Tegaserod, a 5HT4 receptor agonist, Alosetron, a 5HT3 receptor antagonist, and Behaviour Therapy all of which have RCT indicating efficacy.

Geriatrics

24–205 Tube feeding in the elderly: the technique, complications, and outcome.

Dharmarajan TS, Unnikrishnan D. Postgrad Med. February 2004. Vol.115. No.2. p.51–61.

Reviewed by Dr Chris Milne

Review: More people than ever are being tube fed (my term), particularly in our rest homes. This article considers the indications, clinical aspects, possible complications and long term outcome. Ethical aspects are also discussed, and are best considered before the tube is placed; consultation with relatives is crucial.

Comment: Useful article about a challenging problem. For some patients, tube feeding is just delaying the inevitable, whereas for others it can significantly enhance the quality of life.

24–206 Diagnostic evaluation of elderly patients with mild memory problems.

Karlawish JH, Clark CM. Ann Intern Med. 4 March 2003. Vol.138. No.5. p.411–9.

Reviewed by Dr Mike Slatter

Review: This case based discussion focuses on the clinical presentation and diagnostic assessment of elderly patients with mild memory problems. Discusses the relationship between depression and cognitive impairment. A stepwise evaluation of these patients is presented. Stresses office based assessment of cognition and mood and assessment of activities of daily living.

Comment: Evaluation of affect (mood) is part of the routine assessment of memory problems. Offers a good clinical approach. See also 24–207.

24–207 Alzheimer disease: current concepts and emerging diagnostic and therapeutic strategies.

Clark CM, Karlawish JH. Ann Intern Med. 4 March 2003. Vol.138. No.5. p.400–10.

Reviewed by Dr Mike Slatter

Review: See 24–206.

Gynecology

24–208 Bone mineral density in postmenopausal women: does exercise training make a difference?

Miller LE, Nickols-Richardson SM, Ramp WK, et al. Physician and Sportsmedicine. February 2004. Vol.32. No.2. p.18–24.

Reviewed by Dr Rob Campbell

Review: This paper reports on a review of published data on the exercise training effects on bone mineral density in postmenopausal women. Training both aerobic and strength training will help fracture rates but more through better balance and less falls. Preserving bone density is also helped.

Comment: A useful review confirming the benefits of aerobic training on BMD in postmenopausal women. Strength training may also help.

24–209 Red clover extracts not effective for hot flushes.

Gordon A. J Fam Pract. November 2003. Vol.52. No.11. p.846, 848.

Reviewed by Dr Bruce Adlam

Review: Promensil, Rimostil, and placebo all reduced hot flushes by 34% to 41%, without any significant differences between the treatment groups. Scores on the Greene Climacteric quality-of-life scale improved significantly in all three groups, but again without significant differences between the groups. (Original article reviewed: JAMA 2003; 290:207–14.)

Health Services

24–210 Challenges in the care of the acutely ill.

Bion JF, Heffner JE. Lancet. 20 March 2004. Vol.363. No.9413. p.970–7.

Reviewed by Dr Tony Hanne

Review: This is the first of five articles on safety and error in in-patient care. It examines in broad terms the causes of error in industry, aviation or the military and questions when comparison with acute care in the emergency department may be valid. The writers suggest for example that if hospitals are to be compared with the armed services then error in warfare is more appropriate than error in peace time. Fatigue, inadequate training and failure in communication are similarly important. Most significant error relates to system inadequacies but it is the soldier who is court-martialled or the doctor who appears before a disciplinary tribunal and it is not the bureaucrat or the politician who is placed on trial.

Comment: While the focus of this series is on hospitals, the lessons for general practice are still clear. Most of our mistakes are of omission not commission and relate to systems, training and teamwork – or the lack of them. We too need a culture and a setting where we can freely acknowledge what went wrong and learn from it without needing to phone our indemnity insurer first. (For the commentary see 24–211)

24–211 Why blame systems for unsafe care?

McNutt R, Abrams R, Hasler S. Lancet. 20 March 2004. Vol.363. No.9413. p.913–4.
Reviewed by Dr Tony Hanne
Review: See 24–210.

Hemic and Lymphatic Systems

24–212 Diagnostic and management strategies for anaemia in adults.

Doust J. Aust Fam Physician. November 2003. Vol.32. No.11. p.889–94.
Reviewed by Dr Barry Suckling
Review: A good article presenting strategies to identify the cause of anaemia, and uses four case studies to illustrate these principles.

Immunology and Allergy

24–213 Is egg hypersensitivity a contraindication to influenza vaccine?

Nelson MR. Aust Fam Physician. November 2003. Vol.32. No.11. p.932.
Reviewed by Dr Barry Suckling
Review: Is there good evidence to support this, given the strong evidence supporting the value of this vaccination? The author conducted a Medline search and assessed the evidence. He concluded that 'such contraindications' do exist, but the literature supports his advice that 'there is little evidence that egg hypersensitivity leads to adverse outcomes in those receiving influenza vaccine'.
Comment: A balanced one page article and worth a read.

Musculoskeletal System

24–214 Sciatica: patient notes.

Postgraduate Medicine. Postgrad Med. February 2004. Vol.115. No.2. p.65–6.
Reviewed by Dr Chris Milne
Review: This two page handout covers the description, cause, investigation and treatment of sciatica. There is a series of 12 bullet points under the heading 'What can I do to minimise the symptoms?'. It includes appropriate information on urgent presentation if canda equine symptoms develop.
Comment: This is a good article, but is limited by the fact that there is no mention of lumbar epidural steroid injections. In the appropriate clinical setting, where these injections are available, they would be my top recommended treatment.

24–215 Review: some non-surgical interventions improve symptoms in carpal tunnel syndrome.

Yelland M. Evidence-Based Medicine. September/October 2003. Vol.8. No.5. p.147.
Reviewed by Dr Bruce Arroll
Review: Some non surgical interventions improve symptoms in carpal tunnel syndrome. Originally a Cochrane review, this review found limited evidence for short term oral steroids, ultrasound, yoga and splinting and carpal bone mobilisation. (Original article reviewed: Cochrane Database Syst Rev 2003; (2): CD003219)
Comment: The commentator suggests oral steroids may be the easiest to give but there are long term safety concerns. There is other evidence on the benefit of surgery and steroid injections.

24–216 Symptomatic snapping hip: targeted treatment for maximum pain relief.

Idjadi J, Meislin R. Physician and Sportsmedicine. January 2004. Vol.32. No.1. p.25–31.
Reviewed by Dr Rob Campbell
Review: This is a good summary of the causes of snapping or clicking hip. It has some helpful diagrams and describes investigation and management.
Comment: A very useful review to keep as a reference paper.

Nutrition

24–217 Fishing for heart protection.

Marckmann P. Am J Clin Nutr. July 2003. Vol.78. No.1. p.1–2.
Reviewed by Dr Charlotte Cox
Review: This editorial provides a useful summary of current findings from prospective cohort studies and randomised intervention trials looking at the relationship between fish and fish oil consumption and coronary artery disease and coronary artery mortality. The available evidence is as follows:– (1) Consumption of fish and fish oil lowers CAD and total mortality in post-MI patients, but only as long as consumption of fish and fish oil is continued. The reduced CAD mortality in this group may be due to the antiarrhythmic properties of n-3 fatty acids. (2) Fish may be more beneficial than fish oil for three or more reasons. First, fish contains potentially cardioprotective nutrients, such as selenium, various natural antioxidants, and fish protein that are not present in fish oil. Second, fish intake may modify meals in a healthy direction: fish typically replaces red meat, and fish is often consumed with specific foods, such as mustard, dill, and broccoli, that may be healthy but are otherwise seldom eaten. Third, fish is an integrated part of the diet, whereas fish-oil supplementation means adding pure fat to the diet and increasing the risk of weight gain. (3) For patients with stable angina, there is no benefit from eating fish and there may even be harmful effects of consuming fish oil capsules. The apparent negative influence of fish oil on stable angina could be explained by a net proatherogenic effect of fish oil that may modify stable plaques into vulnerable ones. (4) There is insufficient evidence to conclude whether the consumption of fish and fish oil per se influences CAD morbidity and mortality in the general population.
Comment: Interesting to read of the potential adverse effects of fish oil capsule consumption in patients with angina. (For corresponding article see 24–218)

24–218 n-3 Fatty acids and 5-y risks of death and cardiovascular disease events in patients with coronary artery disease.

Erkkila AT, Lehto S, Pyorala K, et al. Am J Clin Nutr. July 2003. Vol.78. No.1. p.65–71.
Reviewed by Dr Charlotte Cox
Review: See 24–217.

24–219 Long-latency deficiency disease: insight from calcium and vitamin D.

Heaney RP. Am J Clin Nutr. November 2003. Vol.78. No.5. p.912–9.
Reviewed by Dr Charlotte Cox
Review: This review article uses the examples of two bone-related nutrients, calcium and vitamin D, to illustrate the difference between short-latency and long-latency nutritional deficiency disease. While the most common disease indices for nutrient deficiency are well known, for example: thiamine deficiency and beriberi; niacin and pellagra; vitamin D and rickets; iodine and goitre, what isn't emphasised is that these deficiency diseases represent only the short-latency component of the disease. So often the approach of nutritional science to deficiency disease is to link a single nutrient with a short-latency period single disease mechanism often affecting a single organ. This article emphasises that this single nutrient/short-latency/single disease approach to nutritional deficiency overlooks the far more important aspects of nutritional deficiency disease especially in the aetiology of cancers, cardiovascular disease and central nervous system degeneration. For example, the index disease for calcium is osteoporosis. However, although the role of calcium in bone health is now commonsense, low calcium intakes have also been implicated in a number of nonskeletal disorders. The article explains in length mechanisms by which low calcium intakes produce diseases ranging from short-latency calcium oxalate kidney stones to long-latency reduction in colon cancer. Using the example of vitamin D, the disease index is rickets (or osteomalacia). However, as with the case of calcium, it is now becoming evident that vitamin D operates through other nonskeletal mechanisms. This article goes on to illustrate the role of vitamin D, calcitriol receptors and cancers. Finally, the article suggests that current recommended dietary intakes of certain nutrients are inadequate. Whilst the recommended intakes may reduce the incidence of short-latency deficiency disease they may be inadequate in reducing the risks of major chronic diseases that affect the populations of industrialised nations.
Comment: This article is far more interesting than the title suggests. Currently, from the standpoint of nutrition, the long-latency disorders such as cancers, cardiovascular disease and degenerative disease of the CNS, constitute a field that is left largely to nutritional quacks and charlatans. However, as General Practitioners we need to be reminded of the important role we play in the proper nutritional assessment and counseling of our patients.

24–220 Diet for the heart or the bone: a biological tradeoff.

Ott SM. Am J Clin Nutr. January 2004. Vol.79. No.1. p.4–5.
Reviewed by Dr Charlotte Cox
Review: This editorial cleverly illustrates the conflict that can arise between dietary recommendations for different chronic diseases using the cardiovascular and skeletal systems as an example. In relation to single nutrients, it appears that in general foods that are good for the heart are also good for the bones, for example, ethanol, fruit and vegetables are beneficial for both systems. However, consideration of total energy intake and BMI suggest a different view. Body weight is one of the most significant factors that determines bone density and fracture risk. The editorial discusses results from a large meta-analysis involving 45 000 persons from nine prospective cohorts and found, with the use of a BMI of 25 as reference, that the relative risk of hip fractures increased from 0.52 in severely obese persons with a BMI of 40 to 4.18 in thin persons with a BMI of 15. Those with a BMI of 20 were twice as likely to fracture a hip as those with a BMI of 25. Similarly, change in body weight is also significantly related to bone density and fracture rates, with a number of studies demonstrating bone density loss with weight loss. The weight loss might be good for the heart but not so for the skeleton.
Comment: This editorial is relevant both to us as general practitioners and consumers. The healthy slogans that bombard us in the supermarket seem to conflict. On the one hand our major problem is with over consumption – yet every slogan seems to advise us to 'eat or drink more of this' because it is 'healthy'. (see also 24–221)

24–221 Nutritional associations with bone loss during the menopausal transition: evidence of a beneficial effect of calcium, alcohol, and fruit and vegetable nutrients and of a detrimental effect of fatty acids.

Madconald HM, New SA Golden MH, et al. Am J Clin Nutr. January 2004. Vol.79. No.1. p.155–65.
Reviewed by Dr Charlotte Cox
Review: See 24–220.

24–222 Importance of identifying the overweight patient who will benefit the most by losing weight.

Reaven GM. Ann Intern Med. 4 March 2003. Vol.138. No.5. p.420–3.
Reviewed by Dr Mike Slatter
Review: This is a perspective review article looking at insulin resistance in obese people. It is this subset of obese people who will most benefit from losing weight. Many overweight and obese people are not insulin resistant. Insulin resistance in obese people can be accurately assessed from blood pressure, plasma glucose, triglyceride and HDL-Cholesterol levels.
Comment: A raised triglyceride (> 1.7 mmol/L) and low HDL-Cholesterol(<1.04 mmol/L) are the strongest predictors of insulin resistance. Efforts at weight reduction can be focussed on this subset of obese patients.

Obstetrics

24–223 Aspirin prevents preeclampsia and complications.

Miller SM. J Fam Pract. December 2003. Vol.52. No.11. p.923–4.
Reviewed by Dr Bruce Adlam

Review: This meta-analysis shows that the use of aspirin in pregnant women predisposed to pre-eclampsia significantly reduces the rates of pre-eclampsia and perinatal death, without evidence of harm. A recent Cochrane review showed similar results. (Original article reviewed: Obstet Gynecol 2003; 101:1319–32.)

Comment: It is reasonable to recommend low-dose aspirin therapy to women who have one or more risk factors for pre-eclampsia.

Oncology

24–224 Current status of PSA screening: early detection of prostate cancer.

Pickle T. Can Fam Physician Med Fam Can. January 2004. Vol.50. p.57–63.
Reviewed by Dr Mike Lyons

Review: An update of the current evidence for PSA screening and a practical approach to patient empowering to make a decision re screening. We await the evidence from two large randomised studies (PLCO and ERSPC expected to be published in 2015!) Until then patient increased demand for PSA needs to be countered with a mixture of science and art. Patient personality and preconceived believes need exploring. Screening may be offered (after patient education re the issues of lead time and length bias, specificity, sensitivity and predictive value of PSA tests and implications of referral to a urologist!) to interested patients 50–75 years with a life expectancy of at least 10 years and with held from non interested patients with no suspect symptoms. Day to day variation of up to 25% in PSA level is common. Age related laboratory levels are important – 0–2.5 (40–49 years), 0–3.5 (50–59 years), 0–4.5 (60–69 years), 0–6.5 (70–79 years). A rate of change in PSA level more than 0.75 per year requires annual testing. Using a free/total ratio cut off point of 25% misses eight per cent of cancers.

Comment: 'In the end there appears to be no right answer'. The challenge is to detect clinically significant cancers at an age and stage when cure is likely and to avoid overdiagnosing low grade tumours – at least till more definitive help in 2015!!

24–225 What's a man to do? Treatment options for localized prostate cancer.

Pickles T. Can Fam Physician Med Fam Can. January 2004. Vol.50. p.65–72.
Reviewed by Dr Mike Lyons

Review: Stratified risk explained on basis of T staging from T1–T4, Gleason score and PSA levels. Options tabled for low, intermediate and high risk patients. Watchful waiting, surgery, external beam radiation therapy and brachytherapy discussed.

Comment: Treatment decision usually facilitated by oncologist and urologist. This article may help us understand their reasoning and enable educated discussion with patients.

24–226 Does finasteride prevent prostate cancer?

Wise AM, Stevermer JJ. J Fam Pract. November 2003. Vol.52. No.11. p.833, 837.
Reviewed by Dr Bruce Adlam

Review: Treatment with finasteride will, over seven years, decrease the prevalence of prostate cancer but increase the likelihood of developing a high-grade cancer. For every 1000 men given finasteride for prostate cancer, 62 will not develop prostate cancer. However, of those that develop prostate cancer, 13 will have higher-grade cancer. (Original article reviewed: N Engl J Med 2003; 349:215–24.)

Comment: It is unclear whether finasteride reduces morbidity or mortality.

24–227 Should we screen for ovarian cancer?

Wiseman PM, Puglia K. J Fam Pract. December 2003. Vol.52. No.12. p.981, 84.
Reviewed by Dr Bruce Adlam

Review: Ovarian cancer screening using pelvic examination, CA–125 serum tumour marker, transvaginal ultrasound (TVU), or any combination of tests is not recommended in average-risk women, or in women with only one first-degree relative with ovarian cancer (strength of recommendation [SOR]=B).

Comment: There is insufficient evidence to recommend for or against screening women with two or more first-degree relatives with ovarian cancer. A careful discussion of risks and benefits to screening is suggested, with referral to specialists as needed to assist in the decision-making (SOR=C).

Prescribing

24–228 Monitoring in high level care.

Shakib S, George A. Aust Fam Physician. November 2003. Vol.32. No.11. p.905–8.
Reviewed by Dr Barry Suckling

Review: Discusses the use of some commonly prescribed medications in elderly nursing home residents and how these medications should be monitored.

Preventive Medicine and Screening

24–229 The Victorian Active Script Programme: promising signs for general practitioners, population health, and the promotion of physical activity.

Sims J, Huang N, Pietsch J, et al. Br J Sports Med. 1 February 2004. Vol.38. No.1. p.19–25.
Reviewed by Dr Chris Milne

Review: This report on the Aussie equivalent of our Green Prescription programme details the method and results, plus economic analysis. The authors estimate it cost $138 per patient to become sufficiently active to gain health benefits, and $3647 per disability adjusted life year saved.

Comment: As always, the authors caution about maintenance of patients activity levels. Dropouts are a problem everywhere. I'm not sure how the costs compare with NZ.

Psychiatry and Psychology

24–230 Structured problem solving in general practice.

Blashki G, Morgan H, Hickle IB, et al. Aust Fam Physician. October 2003. Vol.32. No.10. p.836–42.
Reviewed by Dr Barry Suckling
Review: This is the third article in a series on psychological treatments in general practice. Structured problem solving involves isolating patient problems and tackling them individually using a systematic approach.
Comment: Patients most likely to benefit are those suffering from depressive or anxiety problems, or those overwhelmed by problems. (see also 24–231).

24–231 Cognitive behavioural strategies for general practice.

Blashki G, Richards JC, Ryan P, et al. Aust Fam Physician. November 2003. Vol.32. No.11. p.910–7.
Reviewed by Dr Barry Suckling
Review: The fourth article in the 'psychological treatments in general practice' series. Describes a practical approach to cognitive behavioural strategies using patient handouts and worksheets. (see also 24–230).

24–232 Post-traumatic stress in former Ugandan child soldiers.

Derluyn I, Broekaert E, Schuyten G, et al. Lancet. 13 March 2004. Vol.363. No.9412. p.861–3.
Reviewed by Dr Tony Hanne
Review: This research letter reports the totally predictable. Sixty-nine out of 71 children abducted at on average 12.9 years of age who escaped after more than two years as child soldiers in the Lord's Resistance Army in Northern Uganda suffered clinical post-traumatic stress disorder. The only mystery is that two did not. The ordeal of the abuse to which they were subjected, and the atrocities they were compelled to watch and then carry out against their own people are horrific and sickening.
Comment: The scale of the problem of child soldiers seems overwhelming, 8000 in Uganada and 300 000 worldwide annually in 50 countries. It is arguably worse than the scourge of slavery in the 18th and 19th centuries which we now regard as part of a less civilised age. Developed countries have the resources but not apparently the will to stop this. By comparison our NZ problem of child abuse to which, quite properly, we devote much time and energy seems trivial.

24–233 Review: continuing treatment with antidepressants reduces the rate of relapse or recurrence of depressive symptoms regardless of duration of treatment before or after randomisation.

Simon G. Evidence-Based Medicine. September/October 2003. Vol.8. No.5. p.137.
Reviewed by Dr Bruce Arroll
Review: Continuing treatment with antidepressants reduces the rate of relapse or recurrence of depressive symptoms regardless of duration of treatment before and after randomisation. This review found a benefit for giving continuation therapy after an episode of depression. (Original article reviewed: Lancet 2003; 361:653–61)
Comment: The commentator suggests that it is difficult to tell who will need this continuation medication but that depression is a chronic disease and we need to consider the need for long-term medication.

24–234 What is the best initial treatment of Parkinson's disease?

Schreck J, Kelsberg G, Rich J. J Fam Pract. November 2003. Vol.52. No.11. p.897–9.
Reviewed by Dr Bruce Adlam
Review: No studies clearly demonstrate the best initial treatment for Parkinson's disease. Levodopa improves motor function in Parkinson's disease, however, long-term use is associated with irreversible dyskinesias and motor fluctuations. Compared with placebo, selegiline improves the motor symptoms of Parkinson's disease and allows a physician to delay the introduction of levodopa by nine to 12 months (strength of recommendation [SOR]: A, based on randomised controlled trials). Dopamine agonists-alone or combined with levodopa-have fewer associated dyskinesias and other motor complications but produce lower scores on activities of daily living (SOR: A, based on systematic reviews of randomised controlled trials). Drug choices should be based on each patient's individual symptoms and response to medication.
Comment: A good, brief evidence based article.

24–235 Sertraline effective for children and adolescents with major depression.

Hritzak K, Culhane NS. J Fam Pract. January 2004. Vol.53. No.1. p.11–2.
Reviewed by Dr Bruce Adlam
Review: Sertraline (Zoloft) is effective and generally well tolerated for the short-term treatment of major depressive disorder in both children and adolescents. (Original article reviewed: JAMA 2003; 290:1033–1041)
Comment: Although the studies were not powered to detect a difference in efficacy and safety between age groups, decreased efficacy and increased side effects were seen in children ages six to 11 years. Because treatment with sertraline was only studied for 10 weeks, the efficacy and safety of long-term treatment remain unknown. The most common adverse events reported were insomnia, diarrhoea, vomiting, anorexia, and agitation.

Research Design and Methodology

24–236 Interpretation of confidence intervals.

Rao G. J Fam Pract. December 2003. Vol.52. No.12. p.970.
Reviewed by Dr Bruce Adlam
Review: Excellent one page item that simply explains confidence intervals.

Respiratory System

24–237 Nebulized epinephrine does not help bronchiolitis.

Misra S, Stevermer JJ. J Fam Pract. November 2003. Vol.52. No.11. p.845–6.
Reviewed by Dr Bruce Adlam
Review: This was a multicentre, randomised, double blind, placebo-controlled study in Queensland. Nebulized epinephrine does not improve clinical status or reduce the length of the hospital stay in infants aged <one year with acute bronchiolitis. It also does not reduce clinical scores during or shortly after medication administration. (Original article reviewed: N Engl J Med 2003; 349: 27–35.)

24–238 Do systemic corticosteroids lessen symptoms in acute exacerbations of COPD?

McDiarmid T, Mackler L. J Fam Pract. December 2003. Vol.52. No.12. p.979–80.
Reviewed by Dr Bruce Adlam
Review: Systemic corticosteroids improve measures of dyspnoea in patients with acute exacerbations of chronic obstructive pulmonary disease (COPD) (strength of recommendation [SOR]: A, meta-analysis of two small randomised controlled trials).
Comment: The optimal dose of systemic corticosteroids to achieve these benefits is uncertain. An international consensus panel recommended 30 to 40 mg of oral prednisone daily for 10 to 14 days as a reasonable compromise of efficacy and safety (SOR: C, consensus expert opinion).

Rheumatic Diseases

24–239 A topical cream containing glucosamine and chondroitin sulphate reduced joint pain in osteoarthritis of the knee.

Reginster J-Y. Evidence-Based Medicine. September/October 2003. Vol.8. No.5. p.154.
Reviewed by Dr Bruce Arroll
Review: A topical cream containing glucosamine and chondroitin sulphate reduced joint pain in osteoarthritis of the knee. This study found a benefit which persisted for eight weeks for a cream containing the above components. (Original article reviewed: J Rheumatol 2003; 30:523–8.)
Comment: The commentator suggests this adds to the options for this condition. I am not sure if this form of glucosamine and chondroitin is available in New Zealand but word is sure to get out.

24–240 Glucosamine and chondroitin effective for knee osteoarthritis.

Longyhore DS, Seaton TL. J Fam Pract. December 2003. Vol.52. No.12. p.919–20.
Reviewed by Dr Bruce Adlam
Review: The authors of this meta analysis while acknowledging some of the studies are not of high quality suggest clinicians should consider glucosamine and chondroitin as viable first-line treatment options to reduce the symptoms of knee osteoarthritis, especially for patients who cannot tolerate or in whom NSAIDs are contraindicated. (Original article reviewed: Arch Intern Med 2003; 163:1514–22.)

Sexually Transmitted Diseases

24–241 Sexually transmitted disease: easier screening tests, single-dose therapies.

Campos-Outcalt D. J Fam Pract. December 2003. Vol.52. No.12. p.965–9.
Reviewed by Dr Bruce Adlam
Review: This item focuses on three prevalent STDs: syphilis, gonorrhoea, and chlamydia – those patients most likely to be infected, and specific developments in screening, diagnosis, and treatment.
Comment: There are good tables for single dose treatments.

Sports and Sports Medicine

24–242 Clinical investigation of athletes with persistent fatigue and/or recurrent infections.

Reid VL, Gleeson M, Williams N, et al. Br J Sports Med. 1 February 2004. Vol.38. No.1. p.42–5.
Reviewed by Dr Chris Milne
Review: 41 athletes with persistent fatigue and/or recurrent infections were evaluated clinically and had a wide range of laboratory tests. Conditions with the potential to cause fatigue and/or recurrent infections were identified in 68% of the athletes.
Comment: The authors report a wider range of laboratory tests than would be ordered by most clinicians in primary care (but then they are pathologists!) As a doctor who has worked in both general and specialist practice, I believe that overtraining is still the most important issue, and athletes and coaches are often reluctant to accept that it is often the major contribution to their fatigue. Minor perturbations of results just outside the reference range often occur as a statistical issue, and should not be accepted as the cause of malaise until 'big picture' issues such as training errors, dehydration and glycogen depletion have been investigated in depth.

Technology

24–243 Facts versus ideology in the cloning debate.

The Lancet. Lancet. 21 February 2004. Vol.363. No.9409. p.581.
Reviewed by Dr Tony Hanne
Review: This well reasoned editorial examines how the world's news media handle the emotional word 'cloning' without necessarily understanding that not all stem cell research is the same. This comment was provoked by publication of South Korean research describing the production of pluripotent embryonic stem cells from unfertilised oocytes. Such stem cells could be induced to form a new organ for their original owner. The writer points out that this is very different from using aborted or artificially made foetuses.
Comment: The main issue for the future of this research should not be about the destruction of a life, which does not happen in this situation. The real question is the huge cost of such a procedure when the world health

budget is unable to afford even basic care for so many.

Therapeutics

24–244 The role of exercise prescription in chronic disease.

Moore GE. Br J Sports Med. 1 February 2004. Vol.38. No.1. p.6–7.
Reviewed by Dr Chris Milne

Review: Our current understanding of exercise prescription is limited for most chronic diseases. Traditionally, orthopaedics and rheumatology have controlled neuromuscular rehabilitation. A better clinical paradigm is needed. The author argues that we should look at all forms of exercise as integral to the physical, metabolic, emotional and spiritual robustness of patients.
Comment: Hear hear! All doctors should be trained to prescribe exercise, and have the time and incentive to do so.

24–245 Chronic fatigue syndrome: matching exercise to symptom fluctuations.

Skinner JS. Physician and Sportsmedicine. February 2004. Vol.32. No.2. p.28–32.
Reviewed by Dr Rob Campbell

Review: A review of how exercise affects patients with CFS. (NB: The online version has the wrong introduction – print version is fine). Advice to patients can be generalised to encourage exercise every day at a level just below that which exacerbates fatigue.
Comment: A useful paper to encourage you to keep pushing CFS patients to exercise. This avoids the fatigue, low fitness, fatigue cycle.

Urology

24–246 Local heat decreases renal colic pain.

Page C, Newton W. J Fam Pract. November 2003. Vol.52. No.11. p.838, 840.
Reviewed by Dr Bruce Adlam

Review: This small study demonstrates local heat decreases the pain, anxiety, and nausea of renal colic during emergency transport. (Original article reviewed: J Urol 2003; 170:741–4.)

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