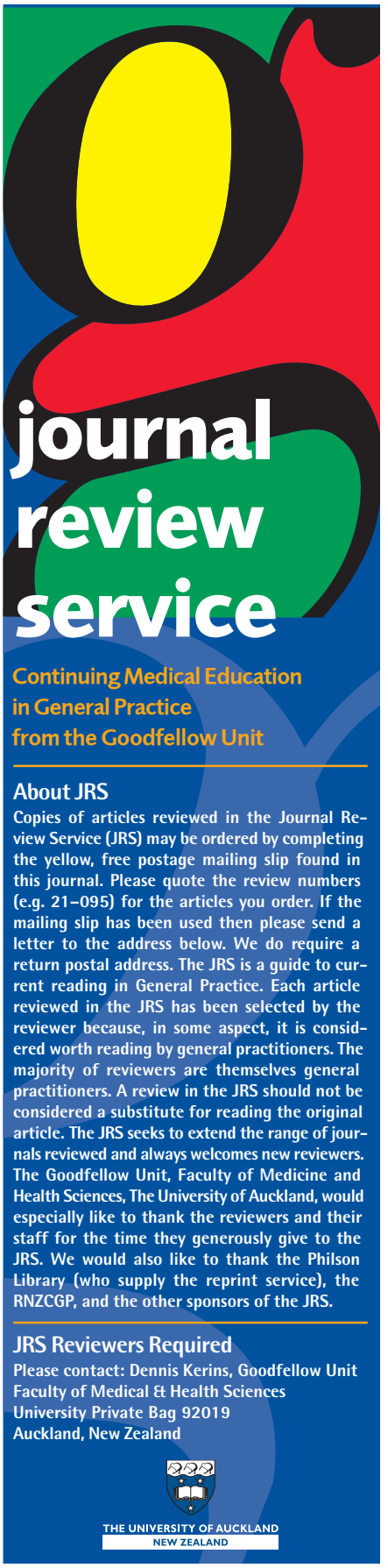

Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Am Fam Physician*
Aust Fam Physician*
BMJ*
Br J Sports Med*
Can Fam Physician Med Fam Can*
Complementary Therapies in Medicine
Drug Alcohol Rev*
Eur J Pain*
Evidence-Based Medicine*
Headache*
Intern Med J*
J Fam Pract*
J Psychosom Res*
Lancet*
Neurosci Lett*
Obes Res*
Obstet Gynecol*
Palliative Med*
Pediatrics*
Rheumatology*
Sci Am*
*Journals indexed in Medline

Acupuncture

26–175 In vivo dc and ac measurements at acupuncture points in healthy and unhealthy people

Prokhorov EF, Prokhorova TE, Gonzalez-Hernandez J, et al. Complementary Therapies in Medicine. March 2006. Vol.14. No.1. p.31-8.

Reviewed by Dr Alex Chan

Review: The study found that direct current and alternating current resistance of acupuncture points in one ethnic group (Mexicans) was four to five times larger than that in another ethnic group (Ukrainians). Additional skin impedance measurements in three groups of Mexicans with different skin colouration were basically the same, indicating that the difference in ethnic groups was not related to skin colour. On the other hand, the acupuncture point capacitances of the two ethnic groups at low frequency were found to differ by not more than 25%. Also, the impedances of acupuncture points related to diseased organs were found to be smaller than the resistances measured by direct current, with both lower than those on the normal skin.

Comment: Experimental figures obtained appeared impressive but were not analysed by statistical methods. However, it does raise the question of interpretation of measurement results in ethnic groups using standard information obtained from another. Significance of lower impedance or resistance in acupuncture points related to diseased organs comparing to normal skin has not been confirmed by statistical analysis in this study.

26–176 Acupuncture for the relief of cancer-related pain – a systematic review

Lee H, Schmidt K, Ernst E. Eur J Pain. August 2005. Vol.9. No.4. p.437-44.

Reviewed by Dr Alex Chan

Review: The purpose of the paper was to systematically review clinical studies of the effect of acupuncture on pain relief in cancer patients. Seven databases were searched but finally only seven studies were included in the review after selection with a modified Jadad scale, taking into consideration the randomisation method, blinding, and description of withdrawals and dropouts in the studies. Of the seven studies, only one was a high quality randomised clinical trial of ear acupuncture which showed statistically significant pain relief. All the other studies were ei-

ther non-blinded or uncontrolled and suffered from methodological flaws.
Comment: The authors concluded that the belief of acupuncture being effective for pain relief in cancer patients was not supported by evidence available at this stage and that further appropriately-powered studies would be required.

26–177 Acupoint-specific fMRI patterns in human brain

Yan B, Li K, Xu J, et al. Neurosci Lett. August 2005. Vol.383. No.3. p.236-40.
Reviewed by Dr Alex Chan
Review: In this study, fMRI scans were obtained prior to and after manual needling one of the following points at random: LR-3, LI-4, 10mm distal to LR-3 and 10mm distal to LI-4. The authors proposed that by subtracting fMRI brain images obtained by stimulating the 'real' acupoint from those obtained by stimulating the 'sham' acupoint, they were able to provide precise and specific patterns in relation to the stimulation of the specific acupoints. There were more activation areas than deactivation areas induced by stimulation of LR-3 and the reverse was noted when LI-4 was stimulated. Also, distinct response patterns were demonstrated with stimulation of LR-3 and LI-4 which was consistent with the notion that different acupoints could be used to treat different conditions.
Comment: It is important to note that this study showed that sham acupoints stimulation resulted in activation of various parts of the brain, hence the need for 'subtraction' of the fMRI images. Also, not all sham acupuncture points are the same. 'Sham LR-3' and 'sham LI-4' actually activated different parts of the brain. This confirms that real sham acupuncture is very difficult to achieve. An interesting article.

26–178 The effect of acupuncture on motor cortex excitability and plasticity

Lo YL, Cui SL, Fook-Chong S. Neurosci Lett. August 2005. Vol.384. No.1-2. p.145-9.
Reviewed by Dr Alex Chan
Review: In this study the effects of acupuncture on motor cortex excitability and plasticity in eight healthy subjects were explored with the use of transcranial magnetic stimulation. Needling duration and the use of both real and sham acupuncture points were found to have significant influence on the amplitudes of the motor evoked potentials amplitudes produced. In this study, there was no significant change in the H-reflex amplitudes with acupuncture in five healthy subjects.
Comment: The conclusion of this study is limited by the small number of participants and the duration of acupuncture needling (only up to 15 minutes). It was interesting that sham needling was also noted to have some effects though only temporarily and is not totally inactive.

Alcohol and Substance Abuse

26–179 The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia

Degenhardt L, Knox S, Barker B, et al. Drug Alcohol Rev. November 2005. Vol.24. No.6. p.499-506.
Reviewed by Dr Helen Moriarty
Review: This study seems to be similar to our own MaGPIe/NatMedCa studies in looking at the frequency of management of such AOD issues by GPs. A random sample of 1000 Australian GPs give details on 100 patients each. From this the annual national GP encounter rate was calculated. 1.3% of all encounters with GPs is estimated to be the frequency of AOD management. This is unbelievably low, especially since it includes tobacco use (which applies to 20% of Australians aged >14 years).
Comment: Certainly, patients do not present their AOD use problem as the primary complaint, but this also indicates that Australian GPs do not think to ask, and accept avoidance or denial at face value. Here's hoping NZ doctors do this better by now. Have you seen the alcohol CME web site? http://www.rnzcgp.org.nz/alac/homePage.htm

26–180 Natural medicines for alcoholism treatment: a review

Xu BJ, Zheng YN, Sung CK. Drug Alcohol Rev. November 2005. Vol.24. No.6. p.525-36.
Reviewed by Dr Helen Moriarty
Review: Medicinal plants have been used in China for centuries for the treatment of alcoholism. They have preventive and therapeutic effects but without many of the unpleasant side effects of prescription medicines used for the same purpose. Recent evidence and research on pharmacological properties throw new light on anti-alcoholism therapy.

Comment: A very interesting paper. These substances act in different ways: Some on alcohol absorption, some on metabolism, some on end-organ protection. There is room in this field of therapy for additional tools to assist patients and some likely candidates amongst these natural remedies for prescription medicines of the future.

Alcohol Drinking

26–181 Implementation of brief alcohol intervention in primary health care: do nurses' and general practitioners' attitudes, skills and knowledge change?

Aalto M, Pekuri P, Seppa K. Drug Alcohol Rev. November 2005. Vol.24. No.6. p.555-8.
Reviewed by Dr Helen Moriarty

Review: This was an implementation project supported by a before and after questionnaire in Finland. Primary care health services in Tampere, a university hospital city, participated. This study was part of a larger WHO Collaborative Project on identification and management of alcohol-related problems in primary health care. The intervention not only did not change frequency of asking questions about the alcohol use of patients; it also did not assist in development of positive attitudes and skills, despite the increase in knowledge – especially the knowledge base of nurses.

Comment: Clearly there are 'barriers to asking' about drugs and alcohol that a survey of this kind does not address.

Asthma

26–182 Review: anticholinergics in addition to beta2 agonists improve outcome in children and adults with acute asthma

Thien F. Evidence-Based Medicine. February 2006. Vol.17. No.1. p.21.
Reviewed by Dr Bruce Arroll

Review: This was a systematic review of 32 RCTs comparing anticholinergic agents such as Ipratropium and Oxitropium with beta agonists versus beta agonists alone. There was a benefit for admissions to hospital in favour of the combination of 13 for children and 15 for adults. (Original article reviewed: Thorax 2005; 60:740-6)

Comment: The commentator said seven of the 32 trials analysed used metered dose inhalers rather than nebulisers for the inhaled medications. Time to add an anticholinergic to your beta agonist.

Cardiovascular System

26–183 Practice tips: anticoagulation for atrial fibrillation

Greiver M. Can Fam Physician Med Fam Can. December 2005. Vol.51. p.1629.
Reviewed by Dr Mike Lyons

Review: One page only from the Practice Tips section. States anticoagulation reduced the risk of stroke in patients with atrial fibrillation by 68%. Cautions that warfarin causes life-threatening bleeding in 1% of patients per annum increasing to 3.4% in patients over 80 years. Risk of severe non life threatening bleed is up to 7.1% per annum for patients over 50 years. Aspirin reduced the risk of stroke by 20%.

Comment: Individual patient risk is calculated with the help of a personal digital assistant available at www.statcoder.com. A patient handout is at http://drgreiver.com/afib.htm

26–184 Non-invasive multislice computed tomography coronary angiography for imaging coronary arteries, stents and bypass grafts

Soon KH, Kelly A-M, Cox N, et al. Intern Med J. January 2006. Vol.36. No.1. p.43-50.
Reviewed by Dr Helen Moriarty

Review: Coming your way soon (if not here already) is coronary angiography without the risk of femoral arterial puncture. This paper includes pretty pictures. It has a major role in investigation of low risk or borderline patients identified by stress test.

Comment: This test will not entirely replace traditional angiography, but will help to identify those that need the invasive technique to assist operative planning. The test has good negative predictive value, but not such good positive predictive value, hence the need for selective angiography if test is positive.

26–185 Review: angiotensin converting enzyme inhibitors and angiotensin receptor blockers prevent atrial fibrillation

Karthikeyan VJ, Lip GY. Evidence-Based Medicine. February 2006. Vol.11. No.1. p.15.
Reviewed by Dr Bruce Arroll

Review: This paper found that these two drugs reduced the risk of atrial fibrillation in patients with CHF and previous AF but this was not significant in patients with hypertension or previous MI. The numbers needed to treat overall was 53 but as low as six for previous AF. (Original article reviewed: J Am Coll Cardiol 2005; 45:1832-9)

Comment: This is certainly something to consider in those who have had AF. The commentator made the point that this may have more to do with the remodelling of the atrium/ventricle than the electrical pathways.

26–186 Diagnosis and management of diastolic dysfunction and heart failure

Satpathy C, Mishra TK, Satpathy R, et al. Am Fam Physician. 1 March 2006. Vol.73. No.5. p.841-6.
Reviewed by Dr Andrea Steinberg

Review: Diastolic heart failure occurs when signs and symptoms of heart failure are present but left ventricular systolic function is preserved (i.e. ejection fraction greater than 45 per cent). All patients with systolic dysfunction have concomitant diastolic dysfunction; therefore, a patient cannot have pure systolic heart failure. In contrast, certain cardiovascular diseases such as hypertension may lead to diastolic dysfunction without concomitant systolic dysfunction. With early diagnosis and proper management the prognosis of diastolic dysfunction is more favourable than that of systolic

dysfunction. Although diastolic heart failure is clinically and radiographically indistinguishable from systolic heart failure, normal ejection fraction and abnormal diastolic function in the presence of symptoms and signs of heart failure confirm diastolic heart failure.
Comment: Although conclusive data on specific therapies for diastolic heart failure are lacking, guidelines recommend that physicians address blood pressure control, heart rate control, central blood volume reduction, and alleviation of myocardial ischemia with combinations of the following agents: angiotensin-converting enzyme inhibitors, angiotensin receptor blockers, diuretics, and beta blockers.

26-187 Atenolol and cardiovascular risk: an issue close to the heart

Wilkinson IB, McEniery CM, Cockcroft JR. Lancet. 25 February 2006. Vol.367. No.9511. p.627-9.
Reviewed by Dr Tony Hanne
Review: Why do beta-blockers and thiazides have as good an effect on blood pressure as ACE inhibitors and calcium channel blockers but far less benefit in outcome? The answer is surprisingly simple. Beta-blockers lower brachial blood pressure but not aortic pressure whereas the other agents lower both. The difference has to do with beta-blockers' action in slowing the heart rate but increasing wave reflection in the arterial tree. Higher aortic pressure is damaging to coronary arteries. Carotid pressure and therefore aortic pressure can be measured by applanation tonometry and may be the way of the future.
Comment: Beta-blockers as first line treatment for hypertension are on the way out. Sphygmomanometers may follow them!

Cerebrovascular System

26-188 Cerebral emboli as a potential cause of Alzheimer's disease and vascular dementia: case-control study

Purandare N, Burns A, Daly KJ, et al. BMJ. 28 April 2006. Vol.Epub. p.1-6.
Reviewed by Dr Len Brake
Review: It is known that micro-emboli entering the cerebral circulation during open heart/carotid surgery is associated with cognitive deficits and memory loss. This case control study measured spontaneous cerebral emboli in patients with Alzheimer's disease compared with controls.
Comment: The findings that these micro-emboli are significantly associated with Alzheimer's may mean that this type of dementia is potentially preventable.

26-189 What sort of evidence do we need in primary care?

Mickan S, Askew D. BMJ. 18 March 2006. Vol.332. No.7542. p.619-20.
Reviewed by Dr Peter Woolford
Review: In this editorial an Australian general practice academic broadens the discussion started by Jonathan Mant et al. in the next paper (see 26-190). She argues that randomised controlled trials are only part of what we need to base our decisions on in general practice and that our relationship with and involving our patients in decision making has a large impact that is not well understood.

26-190 Applicability to primary care of national clinical guidelines on blood pressure lowering for people with stroke: cross sectional study

Mant J, McManus RJ, Hare R. BMJ. 18 March 2006. Vol.3332. No.7542. p.635-7.
Reviewed by Dr Peter Woolford
Review: UK guidelines for BP lowering in patients with stroke are based on findings from the PROGRESS trial. However, the trial's population drawn from secondary care is not the same as the general practice stroke population, and hence the guideline's validity for use in the general practice setting is questioned.
Comment: This study highlights the risk in accepting data from populations that may have a selection bias and not the same as the general practice population (see editorial 26-189).

Communicable Diseases, Infections and Parasites

26-191 Management of chronic hepatitis B virus infection: a new era of disease control

Farrell GC, Teoh NC. Intern Med J. February 2006. Vol.36. No.2. p.100-13.
Reviewed by Dr Helen Moriarty
Review: A review article which gives the background to chronic Hep B infection and explains goals of treatment and treatment options. Case selection for treatment is important and there is a helpful flow diagram on page 104. This is an Australian paper so drug availability can be an issue for NZ patients. For those who can access peginterferon and lamivudine the paper gives helpful information on dose-response and side- effects. Table 4 may be helpful as a summary to discuss Rx with patients who are to start on lamivudine. The paper also touches on new agents on the horizon.

26-192 Avian influenza H5N1: is it a cause for concern?

Jennings LC, Peiris M. Intern Med J. March 2006. Vol.36. No.3. p.145-7.
Reviewed by Dr Helen Moriarty
Review: This editorial is co-authored by a New Zealander and a Hong Kong physician. A viral RNA look back on the 1918 pandemic supports a hypothesis that this was a virus of avian origin, which adapted itself to human transmission. No wonder the hype! The editorial briefly mentions the current approaches, vaccine, antivirals and public health measures.
Comment: The public have been exposed to intensive campaigns over a virus that cannot yet be transmitted human-to-human. However Robert Baden Powell was wise – we should 'be prepared'.

26-193 The bug buster kit was better than single dose pediculicides for head lice

Dawes M. Evidence-Based Medicine. February 2006. Vol.11. No.1. p.17.
Reviewed by Dr Bruce Arroll
Review: This was a randomised trial (without allocation concealment)

where malathion (Derbac-M) or permethrin (Lyclear) was compared with four sequential combings on wet conditioned hair with three days between each combing. The combining was better than the pediculicide with a numbers needed to treat of three. (Original article reviewed: BMJ 2005; 331:384-7)
Comment: The commentator said that the single dose of pediculicide was not the recommended practice and that two applications was normal. He also commented that the effectiveness of the pediculicide was very low compared with other studies. He suggested asking parents which option they wanted and going with that.

26–194 Parenteral penicillin for children with meningococcal disease before hospital admission: case–control study

Harnden A, Ninis N, Thompson M. BMJ. 24 March 2006. Vol.Epub. p.1-3.
Reviewed by Dr Len Brake
Review: It used to be the academics' job to go up their ivory tower and spend time and money theorising, making projections, counting the costs and benefits of this treatment and that investigation. Occasionally they came up with a good notion. Jolly good. The coalface GPs were the ones with their feet on the ground keeping medicine as a whole in touch with reality. It is a crying shame that just such a down-to-earth clinician was not included in the set up of this trial. Let's cut to the chase: (a) Children who receive penicillin before admission have more severe disease on reaching hospital; (b) Children given penicillin may have had more severe disease when they were first seen by a GP.
Comment: Those two gems were all that the entire study added to what was already known on the topic. They then ponder that it may have been the penicillin that made the children worse but conclude with a completely unworkable cunning plan – *'This can be answered only by a randomised controlled trial.'* Yeah, right!

Communication

26–195 Medication accuracy and general practitioner referral letters

Carney SL. Intern Med J. February 2006. Vol.36. No.2. p.132-4.
Reviewed by Dr Helen Moriarty
Review: An Australian neurologist reports on an audit of referral letter quality from GPs. All in all the GPs did well – the major deficiency being documentation of OTC meds taken by the patients – this being an issue for about 50% of these particular patients (at nephrology and hypertension tertiary referral centre).
Comment: The author concludes that *'to avoid medical mismanagement, physicians must validate all GP medication lists regardless of their apparent comprehensiveness.'* I thought that the findings as reported did not justify such a comment!

26–196 Accuracy of information on medicines in hospital discharge summaries

McMillan TE, Allan W, Black PN. Intern Med J. April 2006. Vol.36. No.4. p.221-5.
Reviewed by Dr Helen Moriarty
Review: Auckland Hospital records were examined, from a hospital pharmacy perspective, to determine accuracy of information on discharge summaries. Errors included omissions of medicine intended to be continued after discharge, dose and duration errors – some so obvious that the GP would recognise the error, but some that the GP would not know to be incorrect without prompting.
Comment: This was a small snapshot of 100 medical and 100 surgical patient charts, dose and duration errors can range from mildly confusing or inconvenient to very dangerous. Access to the electronic medical record might help the GP continue the treatment plan that the hospital doctors had intended.

26–197 Active listening: more than just paying attention

Robertson K. Aust Fam Physician. December 2005. Vol.34. No.12. p.1053-5.
Reviewed by Dr Rachel Monk
Review: GP registrar, GP teacher or just need a reminder about good communication skills, then this is the article for you.

Ear, Nose and Throat

26–198 Adenoidectomy does not significantly reduce the incidence of otitis media in conjunction with the insertion of tympanostomy tubes in children who are younger than four years: a randomized trial

Hammaren-Malmi S, Saxen H, Tarkkanen J. Pediatrics. July 2005. Vol.116. No.1. p.185-9.
Reviewed by Dr Jocelyn Tracey
Review: 217 children aged one to four years with more than three episodes of acute otitis media in the previous six months, or with chronic otitis media with effusion were randomised to grommets alone, or grommets plus adenoidectomy. Children with adenoid hyperplasia causing obstructive symptoms such as mouth breathing were excluded. During the one year of follow-up there was no significant difference in otitis media episodes, or persistent effusion.
Comment: There is no advantage in having adenoidectomy with grommet surgery.

26–199 Early tymp tubes do not improve outcomes after 3+ years

J Fam Pract. November 2005. Vol.54. No.11. p.929.
Reviewed by Dr Bruce Adlam
Review: Bottom Line: Early insertion of tympanostomy tubes does not improve long-term clinical outcomes of importance (speech acquisition and hearing) in children with persistent otitis media with effusion. Delaying six months for bilateral effusion and nine months for unilateral effusion before revisiting the decision to insert tubes is the preferred approach to management, since it results in fewer procedures with equivalent outcomes. (LOE=1b) (Original article reviewed: N Engl J Med 2005; 353:576-86)
Comment: There was no difference between groups in intelligence tests,

speech complexity, hearing, behaviour, or parental stress.

Education

26–200 Incorporating medical students into your practice

DeWitt DE. Aust Fam Physician. January/February 2006. Vol.35. No.1/2. p.24-6.
Reviewed by Dr Rachel Monk

Review: Despite not being a GP teacher I found this article very interesting.

Comment: Invaluable article, I would think, for GP teachers, either for undergraduates or RNZCGP registrars.

Ethics

26–201 Epilepsy, driving and confidentiality

Bird S. Aust Fam Physician. December 2005. Vol.34. No.12. p.1057-8.
Reviewed by Dr Rachel Monk

Review: Case based medical legal issue around a 22-year-old with epilepsy. Sounds like the legal obligations in Australia are similar to NZ when it comes to driving and epilepsy. Nice little reminder of our role in this area.

26–202 The ethics of palliative care and euthanasia: exploring common values

Hurst SA, Mauron A. Palliative Med. March 2006. Vol.20. No.2. p.107-112.
Reviewed by Dr Peter Woolford

Review: Common values are held by these seemingly two disparate philosophies. They both want to reduce human suffering, both have an aversion to the technical medicalisation of the end of life, emphasise the importance of control by the patient at the end of life, and both recognise that death is not the worst that can happen.

Comment: The palliative care, euthanasia assisted suicide debate is one that we as GPs face every so often. This paper from the Bioethics Institute, Geneva, Switzerland draws common themes in a thoughtful and meaningful fashion and is a worthwhile addition to the debate.

Family Practice

26–203 Can sutures get wet? Prospective randomised controlled trial of wound management in general practice.

Heal C, Buettner P, Raasch B, et al. BMJ. 6 May 2006. Vol.332. No.7549. p.1053-6.
Reviewed by Dr Len Brake

Review: I downloaded this article before I read any detail and I am loathe to waste the wear and tear on my printer by not doing this review. Even the *BMJ* editors conclude that the conclusion of this study, namely: *'Wetting and uncovering sutures in the first 48 hours after minor excisions did not increase the infection rate'*, adds nothing new to what is already known on the topic.

Comment: In an attempt to make controversy out of nothing, the authors express concern that a limitation of their 'findings' could be that too many of the GPs involved were young women.

Gastroenterology

26–204 Epidemiology of the functional gastrointestinal disorders diagnosed according to Rome II criteria: an Australian population-based study

Boyce PM, Talley NJ, Burke C, et al. Intern Med J. January 2006. Vol.36. No.1. p.28-36.
Reviewed by Dr Helen Moriarty

Review: This Australian paper takes a global look at functional GI disorders: globus, chest pain of assumed oesophageal origin, dyspepsia, irritable bowel and anorectal disorders, to name a few. Many functional GI disorders have a waxing and waning quality. The prevalence survey required 12 weeks of symptoms in the past year (Rome II criteria).

Comment: Functional disorders are common – in both sexes. The term 'functional' is unfortunate, since it implies psychological problems. This paper correlates FGIDs to psychological state – but this bypasses the cause or effect debate. This study relies on self-reporting on both counts (FGID and psychological).

26–205 Age, impaired fasting glucose, and cirrhosis predicted mortality at mean 7.6 years for non- alcoholic fatty liver disease

Reichen J. Evidence-Based Medicine. February 2006. Vol.11. No.1. p.26.
Reviewed by Dr Bruce Arroll

Review: This was a follow-up study of 435 men with non-alcoholic fatty liver disease confirmed by radiology. There was an increased mortality by age hazard ratio 2.2, diabetes or impaired fasting glucose hazard ratio 2.6 and cirrhosis 3.1. (Original article reviewed: Gastroenterology 2005; 129: 113-21).

Comment: The commentator on this paper said: In this population the rate of cirrhogenesis was about one in 30 but in the total population one in 3000. He suggested that we need not biopsy the livers of all such people as the hepatic mortality is low and excess mortality is probably caused by complications of diabetes.

26–206 A clinical decision rule to identify children at low risk for appendicitis

Kharbanda AB, Taylor GA, Fishman SJ, et al. Pediatrics. September 2005. Vol.116. No.3. p.709-16.
Reviewed by Dr Jocelyn Tracey

Review: The authors developed a scoring system for three to 18-year-old children with possible appendicitis. Scored items were nausea, right lower quadrant pain, migration of pain, difficulty walking, rebound tenderness and increased neutropil count. A score of 5 or less on a scale of 14, was shown to indicate a low risk of appendicitis, with a sensitivity of 96.3%. Further analysis showed that a rule regarding the absence of nausea, of maximal tenderness in the right lower quadrant and neutrophil count less than 6.75 x 103uL had a sensitivity of 98.1% and a negative predictive value of 97.5%.

Comment: The neutrophil count had the greatest significance – a reminder that it is worth doing.

26–207 Guideline for chronic constipation management

J Fam Pract. November 2005. Vol.54. No.11. p.932.

Reviewed by Dr Bruce Adlam

Review: Bottom Line (pardon the pun): Diagnostic testing is not needed for most patients with chronic constipation. The evidence of efficacy is strongest for psyllium, polyethylene glycol, lactulose, and tegaserod. Research is not available to support the routine use of stimulant laxatives, lubricants, stool softeners, calcium polycarbophil, bran, or any herbal products. (LOE=1a) (Original article reviewed: Am J Gastroenterol 2005; 100:S1-S4)

General

26–208 Who says you cannot get published?

McCrory P. Br J Sports Med. February 2006. Vol.40. No.2. p.95.

Reviewed by Dr Chris Milne

Review: This editorial takes a whimsical look at those papers that relate to the weird or wacky. For example - injuries due to falling coconuts, or electrically monitoring a brain cell in a locus watching selected highlights from 'Star Wars' (this research actually took place in Newcastle University in England).

Comment: As well as who publishes these researchers, you have to ask - who funds these researchers, and if they are state funded, what would the taxpayers think?

Genetics

26–209 Unlocking the secrets of longevity genes

Sinclair DA, Guarente L. Sci Am. March 2006. Vol.294. No.3. p.30-7.

Reviewed by Dr Ron Vautier

Review: With a particular emphasis on a group of enzymes known as sirtuins, this article looks at biochemical pathways that extend animals' life spans. From such knowledge we can also expect new medications to treat diabetes, cancer, heart disease and neurodegenerative conditions.

Comment: Here we have some good explanation as to why calorie-restriction prolongs life.

Geriatrics

26–210 Neurally mediated syncope and unexplained or nonaccidental falls in the elderly

Anpalahan M. Intern Med J. March 2006. Vol.36. No.3. p.202-7.

Reviewed by Dr Helen Moriarty

Review: A personal viewpoint paper, this discusses vasovagal syncope and carotid sinus hypersensitivity as the two common examples of neurally mediated syncope. They are emerging causes for unexplained falls. Retrograde amnesia can occur – especially with CS hypersensitivity – which may explain why the connection with falls has been long overlooked. CS hypersensitivity is the more common of the two and may account for 6–48% of falls (depending on the population studied), and cardiac pacing can be beneficial for symptomatic patients. The role of carotid sinus massage seems controversial in diagnosis.

Guidelines

26–211 Systems for implementing best practice for a chronic disease: management of osteoarthritis of the hip and knee

Brand C, Cox S. Intern Med J. March 2006. Vol.36. No.3. p.170-9.

Reviewed by Dr Helen Moriarty

Review: This paper describes the process to develop a best evidence care guideline for OA of the hip and knee, with particular emphasis on the multiple barriers that exist to prevent optimal adherence to the guideline. This included mapping patient pathways to better understand processes which are difficult to implement.

Comment: This was a hospital-orientated pathway, using booking clerks, clinic nurses and radiology administration as key informants. Guideline development needs to take into account the primary care process also, to ensure that it is fully workable in practice.

Gynaecology

26–212 Effect of oral contraceptives and hormone replacement therapy on bone mineral density in premenopausal and perimenopausal women: a systematic review

Liu SL, Lebrun CM. Br J Sports Med. January 2006. Vol.40. No.1. p.11-24.

Reviewed by Dr Chris Milne

Review: Thus far, studies examining the effect of OC pills and HRT on bone density have produced mixed results. This extensive review reviewed evidence from 75 studies that met quality criteria, and stratified these studies according to health, menstrual status, and reproductive age, to more clearly define the effects of OC pills and HRT.

Comment: A major review article, worth reading by those with an interest in this field.

26–213 Postmenopausal hormone therapy: does it cause incontinence?

Steinauer JE, Waetjen LE, Vittinghoff E, et al. Obstet Gynecol. November 2005. Vol.106. No.5 Part 1. p.940-5.

Reviewed by Dr Len Brake

Review: The Heart oestrogen/progestin replacement study was a randomised placebo controlled double blinded trial to evaluate HRT for the prevention of heart events in women with established heart disease. There was a higher risk of both urge incontinence and stress incontinence. The numbers needed to harm were 8.6 and 6.2 respectively. This increased risk was evident within four months from the start of treatment.

26-214 The effect of ultralow-dose transdermal estradiol on urinary incontinence in postmenopausal women

Waetjen LE, Brown JS, Vittinghoff E, et al. Obstet Gynecol. November 2005. Vol.106. No.5 Part 1. p.946-52.
Reviewed by Dr Len Brake
Review: see 26-213.

26-215 Gabapentin reduces hot flashes in breast cancer survivors

Walling AD. Am Fam Physician. 15 March 2006. Vol.73. No.6. p.1100, 1102.
Reviewed by Dr Andrea Steinberg
Review: These authors randomised 420 women, including tamoxifen users, to either placebo, 300mg gabapentin or 900mg gabapentin a day. From baseline, the third group reported a mean reduction of 44 per cent in occurrence of hot flushes and a 46 per cent reduction in severity. The authors concluded gabapentin at dosages of at least 900mg is effective in reducing symptoms of hot flashes in women with breast cancer. These results correlate with studies in postmenopausal women indicating that higher dosages of gabapentin are required for clinical effect. (Original article reviewed: Lancet September 3, 2005; 366:818-24.
Comment: An interesting option for the GP to offer patients, both breast cancer survivors and possibly those without previous breast cancer.

26-216 Vulvodynia: diagnosis and management

Reed BD. Am Fam Physician. 1 April 2006. Vol.73. No.7. p.1231-8.
Reviewed by Dr Andrea Steinberg
Review: This debilitating disorder is of unknown aetiology: tentative links have been found to neuronal proliferation and minor immunological changes. Allodynia suggests that this might be a primary neuropathic disorder, which could explain why corticosteroids and oestrogen therapy are unhelpful, and why amitryptilene and gabapentin are useful. Differential diagnoses include candidiasis, lichen planus, lichen sclerosis and VIN. Treatments include oral medications that decrease nerve hypersensitivity (e.g. tricyclic antidepressants, selective serotonin reuptake inhibitors, anticonvulsants), pelvic floor biofeedback, cognitive behavioural therapy, local treatments, and (rarely) surgery. There is a comprehensive table detailing use of these therapies.
Comment: A mystifying condition, this overview would be excellent to print and offer to patients. Patient handout attached.

Homeopathy

26-217 A randomised, controlled, triple-blind trial of the efficacy of homeopathic treatment for chronic fatigue syndrome

Weatherley-Jones E, Nicholl JP, Thomas KJ, et al. J Psychosom Res. February 2004. Vol.56. No.2. p.189-97.
Reviewed by Dr Mimi Irwin
Review: This is a good quality controlled trial looking into the homeopathic treatment of people with chronic fatigue syndrome. There were 103 patients who met the Oxford criteria for CFS and they were randomly assigned to either homeopathic treatment or placebo. Ninety-two patients completed the trial, 47 receiving homeopathic medication and the rest placebo. Main outcome measures were scores on the Multidimensional Fatigue Inventory. Eighty-six patients returned the post treatment outcome measures. The homeopathically treated patients showed significantly more improvement for general fatigue and also improvement as regards physical limitation only.
Comment: Although this investigation is well conducted and designed, it is underpowered and would have benefited from around twice the number of patients. This study demonstrates that there is weak evidence to show that homeopathy is better than placebo for the treatment of CFS. Forty-seven per cent of those in the treatment group showed a clinically significant improvement on the general fatigue subscale. Twenty-eight per cent in the placebo group also demonstrated a comparable improvement. In other studies it has been reported that 13% of patients with CFS and no treatment improve. The nonspecific aspects of the homeopathic consultation may be worth further investigation. At this stage the most helpful intervention for CFS appears to be CBT.

26-218 Improved clinical status in fibromyalgia patients treated with individualized homeopathic remedies versus placebo

Bell IR, Lewis DA, Brooks AJ, et al. Rheumatology. January 2004. Vol.43. No.1. p.577-82.
Reviewed by Dr Mimi Irwin
Review: The aim of this American study was to assess the treatment of fibromyalgia with individualised homeopathic medication. The study was well designed in that it was double blind, randomised and placebo controlled. Sixty-two patients were recruited from the community and were treated with daily liquid LM potencies of homeopathic medication or indistinguishable placebos. The primary clinical outcomes were tender point count, tender point pain as assessed by an independent assessor and self rating scales related to quality of life, pain, mood etc. Fifty-three people completed the trial and none dropped out because of adverse side effects. The people who received homeopathic treatment improved significantly in terms of tender point pain, tender point count general health and mood.
Comment: This study has been carefully designed and has a number of excellent features. In particular the use of two homeopaths for remedy selection increased the reliability of remedy selection. The study was of a reasonable duration at three months and the remedies were individualised. It is unfortunate that the sample size was so small at 53. The study however does replicate an earlier study conducted by Fisher in 1989 and these are unusual in the homeopathic literature. This study supports the homeopathic treatment of fibromyalgia. This treatment is safe and now has an evidence base.

Immunology and Allergy

26-219 Intrigue at the immune synapse

Davis DM. Sci Am. February 2006. Vol.294. No.2. p.48-55.
Reviewed by Dr Ron Vautier
Review: Where cells of the immune system contact other cells they form structures very similar to the synapses that nerve cells make with each other. The nature of these structures is important in determining what sort of interaction between the cells takes place.
Comment: Intriguing are the contents, and beautiful are the illustrations.

Law and Medicine

26-220 Does being against euthanasia legislation equate to being anti-euthanasia?

Cartwright CM, Williams GM, Parker MH, et al. Intern Med J. April 2006. Vol.36. No.4. p.256-9.
Reviewed by Dr Helen Moriarty
Review: Previous research by the authors had indicated that health professionals opposed to euthanasia legislation were not necessarily against euthanasia. This qualitative paper attempted to explore reasons why this was so. Changing the law was seen to be problematic; could lead to demand for this service; is not a decision for lawyers or bureaucrats to ring fence; could result in excess red tape; might undermine current legal patient assistance, by intruding into terminal care delivery.
Comment: A survey from aged services research team in NSW. The response rate was 43% from doctors and 45% from nurses and 38% of community members. Some respondents commented that the questionnaire was too complex!

Metabolic Diseases

26-221 Is visceral fat involved in the pathogenesis of the metabolic syndrome? Human model

Jensen MD. Obes Res. February 2006. Vol.14. No.Suppl 2. p.20S-4S.
Reviewed by Dr Anne-Thea McGill
Review: This study uses dog and human models to show that upper body non-visceral fat contributes to the majority of free fatty acids in lean, obese, diabetic, and non-diabetic humans. However, visceral fat mass was also positively correlated with adverse health consequences and excess free fatty acid availability. Systemic, as opposed to hepatic, insulin resistance is more likely to be caused by the large upper body, non visceral fat depot.
Comment: This article may be a wake up call to take notice of our men and women patients who have excess upper body fat, not just those with the big bellies, and who may be at increased CVD risk.

Musculoskeletal System

26-222 Acute finger injuries: Part I. Tendons and ligaments

Leggit JC, Meko CJ. Am Fam Physician. 1 March 2006. Vol.73. No.5. p.810-6.
Reviewed by Dr Andrea Steinberg
Review: Part I of this overview reviews our basic understanding of the anatomy of the finger, common finger injury mechanisms, and when referral is necessary to ensure optimal outcomes after a finger injury. Part II (See 26-223) of this two-part article focuses on the evaluation of finger fractures and dislocations, as well as thumb injuries. Patient handout attached.

26-223 Acute finger injuries: Part II. Fractures, dislocations, and thumb injuries

Leggit JC, Meko CJ. Am Fam Physician. 1 March 2006. Vol.73. No.5. p.827-34.
Reviewed by Dr Andrea Steinberg
Review: See 26-222. Patient handout attached.

Neurology

26-224 Efficacy and safety of exogenous melatonin for secondary sleep disorders and sleep disorders accompanying sleep restriction: meta-analysis

Buscemi N, Vandermeer B, Hooton N, et al. BMJ. 18 February 2006. Vol.332. No.7538. p.385-93.
Reviewed by Dr Len Brake
Review: This meta review yielded an impressive number of reliable RCTs and there is no evidence that melatonin is effective in treating secondary sleep disorders or sleep disorders resulting from jet lag or shift work. There is evidence that melatonin is safe with short term use. A Cochrane review of melatonin for jet lag looked for adverse reactions and found hints of a possible interaction with warfarin and a suggestion of harm to children with severe epilepsy – both these problems remain to be investigated. (See also 26-225).

26-225 Does melatonin help people sleep? It's a misapplied but probably safe miracle drug.

Herxheimer A. BMJ. 18 February 2006. Vol.332. No.7538. p.373-4.
Reviewed by Dr Len Brake
Review: see 26-224.

26-226 Fits, faints and funny turns in children

Mackay M. Aust Fam Physician. December 2005. Vol.34. No.12. p.1003-8.
Reviewed by Dr Rachel Monk
Review: 'Not everything that twitches is a seizure.' This is the general idea of this article which describes the typical features of different types of epilepsy AND the differential diagnoses. Emphasizes the importance of an eye witness account of the 'event'.

26-227 Epilepsy syndromes in children

Carney PW, Prowse MA, Scheffer IE. Aust Fam Physician. December 2005. Vol.34. No.12. p.1009-15.
Reviewed by Dr Rachel Monk
Review: Brief look at the typical features of the different epilepsy syndromes in childhood. Includes a couple of interesting case studies.

26-228 Treatment with antiepileptic drugs

Berkovic SF. Aust Fam Physician. December 2005. Vol.34. No.12. p.1017-20.
Reviewed by Dr Rachel Monk
Review: Treatment is NOT just about drugs. This article also mentions key lifestyle issues. Discussion on the typical best first line drug for different types of epilepsy and the best way to start them as well as monitoring.
Comment: Interestingly this article suggests drug levels have no place in routine monitoring. Interesting section on generic prescribing.

26-229 Febrile seizures

Srinivasan J, Wallace KA, Scheffer IE. Aust Fam Physician. December 2005. Vol.34. No.12. p.1021-5.
Reviewed by Dr Rachel Monk
Review: Febrile seizures are common in children. There is a small increase in risk of developing an epilepsy syndrome. The role of paracetamol is questionable.
Comment: I found this article rather interesting, I hope you do too.

26-230 Oral sumatriptan for the acute treatment of probable migraine: first randomized, controlled study

Tepper SJ, Cady R, Dodick D, et al. Headache. January 2006. Vol.46. No.1. p.115-24.
Reviewed by Dr Len Brake
Review: Headaches with some but not all the features of migraine meet criteria for probable migraine. These headaches are prevalent and frequently under diagnosed. Patients were randomised to receive 25, 50 or 100mg tablets of sumatriptan or matching placebo. The 100mg sumatriptan group had statistically better headache relief suggesting sumatriptan has a place in the acute treatment for the 'probable' migraine.

Nutrition

26-231 Screening and interventions for overweight in children and adolescents: recommendation statement

US Preventative Services Task Force. Pediatrics. July 2005. Vol.116. No.1. p.205-9.
Reviewed by Dr Jocelyn Tracey
Review: This article concludes that the evidence is insufficient to recommend for or against routine screening for overweight in children and adolescents. This is not because of the size of the problem, or difficulty identifying those who are overweight. It is because there is currently insufficient evidence for the effectiveness of behavioural counselling or other preventive interventions that can be delivered in primary care settings.
Comment: An important article for those interested in obesity and a call to more research around programmes being trialled.

Obstetrics

26-232 Is influenza vaccination safe for pregnant women?

Miller KE. Am Fam Physician. 15 February 2006. Vol.73. No.4. p.703.
Reviewed by Dr Andrea Steinberg
Review: The final analysis included 7183 mother–infant pairs. The vaccination rate was 3.5 per cent (252 women). There were no significant differences between the vaccination and control groups with regard to fever, pregnancy outcomes (i.e. preterm labour, preterm delivery, complicated delivery), or problems with the foetus (i.e. poor foetal growth). The infants' medical conditions from birth to six months of age also were not significantly different between the two groups. No adverse events related to the vaccine were reported, and the analysis showed a trend toward a lower incidence of acute upper or lower respiratory tract illnesses in the vaccinated women during the peak influenza season. The authors conclude that inactivated influenza vaccine provided during the second and third trimesters is safe. They add that safety concerns do not justify avoiding the use of the vaccine in pregnant women. (Original article reviewed: Am J Obstet Gynecol April 2005;192:1098-106).

26-233 Adolescent pregnancy: current trends and issues

Klein JD. Pediatrics. July 2005. Vol.116. No.1. p.281-6.
Reviewed by Dr Jocelyn Tracey
Review: This article provides an impressive summary of the data around sexual activity and contraceptive use in adolescents, trends in adolescent childbearing, the medical risks and psychological complications of adolescent pregnancy, and outcomes for the children. There is a useful list of clinical considerations for health professionals, such as offering confidential consultations to adolescent patients, and always discussing all options with pregnant adolescents.
Comment: A useful and informative overview of the topic, from a US perspective.

Oncology

26-234 Locally advanced and inflammatory breast cancer

Ahern V, Brennan M, Ung O, et al. Aust Fam Physician. December 2005. Vol.34. No.12. p.1027-32.
Reviewed by Dr Rachel Monk
Review: The series on breast disease continues. This is essentially a clinical diagnosis, often in younger women and sometimes men too. Imaging is not always helpful.
Comment: Quite a big section on management which is more often than not out of the scope of general practice but also a short section on the GP's role.

26-235 An approach to the patient with a family history of breast cancer

Kirk J, Brennan M, Houssami N, et al. Aust Fam Physician. January/February 2006. Vol.35. No.1/2. p.43-7.
Reviewed by Dr Rachel Monk
Review: As a GP we are often in the situation of having family histories and not necessarily knowing what to do about them. This article will help you go about taking an appropriate family history and to determine who should and who shouldn't have early screening and how to go about it.

Comment: Note – there is also a patient education hand out on page 49/50.

Palliative Treatment

26–236 Radiotherapy basics for family physicians: Potent tool for symptom relief

Samant R, Gooi AC. Can Fam Physician Med Fam Can. November 2005. Vol.51. p.1496-501.
Reviewed by Dr Mike Lyons

Review: Maintains radiotherapy is underused in cancer treatment. Progresses to explain the benefit in treating bone and soft tissue metastasis, haemoptysis, superior vena cava obstruction, spinal cord compression, brain metastasis, dyspnoea and dysphagia. Outlines practicalities of usual course of radiotherapy and associated side effects with treatment suggestions.
Comment: Basic approach – helpful in allaying patient fears.

26–237 Would people with Parkinson's disease benefit from palliative care?

Hudson PL, Toye C, Kristjanson LJ. Palliative Med. March 2006. Vol.20. No.2. p.87-94.
Reviewed by Dr Peter Woolford

Review: Patients, caregivers and health professionals were interviewed regarding the impact of Parkinson's disease. Five themes emerged: (1) emotional impact of diagnosis, (2) staying connected, (3) enduring financial hardship, (4) managing physical challenges, (5) finding help for advanced stages.
Comment: The conclusion was that patients with PD and their families could benefit from a palliative care approach. Palliative care teams around NZ are in fact trying to embrace patients suffering with any terminal condition including PD, and end-stage cardiac, renal, lung disease etc.

Paediatrics

26–238 Watchful waiting enough for children who swallow coins

Shaugnessy AF. Am Fam Physician. 15 February 2006. Vol.73. No.4. p.699.
Reviewed by Dr Andrea Steinberg

Review: Clinical Question: In asymptomatic children, who present with swallowed coins lodged in the oesophagus, is it better to remove the coins immediately or wait and remove them if still present 16 hours later? Setting: Emergency department; Study Design: Randomised controlled trial (non-blinded); Bottom Line: Despite waiting 16 hours, fewer than one in four (23 per cent) oesophageal coins will pass spontaneously. Conversely, 30 per cent of children scheduled for removal will have passed the coin by the time they are prepared for surgery. Based on

the results of this study (spontaneous passage rate = 23 to 30 per cent), eight to 16 hours of observation is appropriate treatment for children with coins in the oesophagus, assuming that the child is asymptomatic, the ingestion was recent, and the child has no underlying oesophageal or tracheal abnormality (Level of Evidence: 1b). (Original article reviewed: Pediatrics September 2005;116:614-9).

26–239 The association between having a medical home and vaccination coverage among children eligible for the vaccines for children program

Smith PJ, Santoli JM, Chu SY, et al.
Pediatrics. July 2005. Vol.116. No.1. p.130-9.
Reviewed by Dr Jocelyn Tracey

Review: This study looked at immunisation rates for vulnerable children who qualified for free vaccines. Children with a medical home (an identifiable doctor or nurse who provides ongoing care – well child, preventive and sick care) and those who had most of the vaccinations at their medical home were more likely to be fully immunised.
Comment: More evidence for the importance of each child having an identifiable medical home.

26–240 Effectivness of the 2003–2004 influenza vaccine among children six months to eight years of age, with 1 vs 2 doses

Ritzwoller DP, Bridges CB, Shetterly S, et al.
Pediatrics. July 2005. Vol.116. No.1. p.153-9.
Reviewed by Dr Jocelyn Tracey

Review: An interesting article about vaccinating children aged less than eight years for influenza. Two doses were required for effective immunity if the children had not been previously immunised against flu. There was significant protective effect against flu like illnesses for those fully immunised, but not for those only partially immunised (Hazard rate Ratio: 0.32). There was no reduction in rates of pneumonia. Children aged less than 11 months, those with asthma, allergic rhinitis or a history of script of gastroprotective medication were all associated with increased rates of flu like illness.
Comment: Interesting article for parents wondering about immunising their small children against flu.

Physician–Patient Relations

26–241 Somatisation: a joint responsibility of doctor and patient

Bensing JM, Verhaak PF. Lancet. 11 February 2006. Vol.367. No.9509. p.452-4.
Reviewed by Dr Tony Hanne

Review: Whose idea is it to presume that psychosocial problems have biomedical pathologies? This discussion of a study based on 420 audiotaped consultations suggests that the first suggestion of a physical cause

to a patient's illness came as often from the doctor as the patient. Once the possibility was raised, it was picked up and developed by the patient. The doctor in return responded by proposing tests or referrals. When these were negative it became more difficult to steer the patient back to life stresses. The doctor in turn became frustrated with a new 'heartsink' patient.
Comment: The secret still lies in what we have talked about in general practice for many years, patient-centred consultations in which the doctor patient relationship is a vital diagnostic and therapeutic tool, not part of the pathology.

Practice Management

26-242 Using computers to work smarter: a guide for GPs

Schattner P. Aust Fam Physician. January/February 2006. Vol.35. No.1/2. p.28-31.
Reviewed by Dr Rachel Monk
Review: By now most GPs use computers. This article looks at getting the most out of them from management to clinical uses.
Comment: Of course there are always hurdles but these are worth overcoming in order to enjoy the benefits that computers offer.

Preventive Medicine and Screening

26-243 Evidence-based periodic health examination of adults: memory aid for primary care physicians

Milone SD, Milone SL. Can Fam Physician Med Fam Can. January 2006. Vol.52. p.40-7.
Reviewed by Dr Mike Lyons
Review: A checklist produced by two physicians to help implement an evidence based approach to screening and 'check up' examinations. Based on the recommendations from the Canadian Task Force on Preventative Health Care, (whose disappearance due to lack of funding is a great loss) and the United States Preventative Services Task Force. Divided into the following sections - current patient concerns, current medications, review of systems, social history, past medical and family history, physical examination, counselling issues, investigations and treatment. Grade A and B evidence used mostly but grade C included based on potential benefit to individual patients and availability of tests.
Comment: Form was well accepted when trialled in academic and community Canadian practices. May need an electronic version to tempt Kiwis! (see 26-244).

26-244 Preventive Care Checklist form: evidence-based tool to improve preventive health care during complete health assessment of adults

Dubey V, Glazier R. Can Fam Physician Med Fam Can. January 2006. Vol.52. p.48-55.
Reviewed by Dr Mike Lyons
Review: Another check list (see 26-243) from Canada to aid the annual medical examination. Separate forms produced for male and female (the latter shown in the article). Bold text indicates good evidence; italics text, fair evidence and plain text, guidelines.
Comment: Interesting to compare the two checklists, the first from Queen's University in Kingston and the second from the University of Toronto – both Ontario. The forms can be located at www.cfp.ca under Health Policy, Family Practice Resources (http://www.cfpc.ca/English/cfpc/communications /health%20policy/Preventive%20Care%20Checklist%20Forms/Intro/default.asp?s=1)

26-245 Prevention: Building on routine clinical practice

Sim MG, Khong E. Aust Fam Physician. January/February 2006. Vol.35. No.1/2. p.12-5.
Reviewed by Dr Rachel Monk
Review: It is well recognised that prevention and health promotion should be the role of GPs, but it's not always done well. This article looks at how we might do this.
Comment: What could you do in your practice?

26-246 Cancer screening: benefits, harms and making an informed choice

Barratt AL. Aust Fam Physician. January/February 2006. Vol.35. No.1/2. p.39-42.
Reviewed by Dr Rachel Monk
Review: Although screening sounds like a good idea, any screening still needs to be evidence based. There is always a risk of over detection and over treatment, false positives and false negatives. Of course there are benefits of screening too.
Comment: All in all it is important to weigh up benefits and harms and make informed choices. This article has some information to help you do this.

Public Health

26-247 Benefits of exercise therapy for chronic diseases

Kujala UM. Br J Sports Med. January 2006. Vol.40. No.1. p.3-4.
Reviewed by Dr Chris Milne
Review: There is accumulating evidence from randomised controlled trials that exercise is a powerful tool for prevention and treatment of 'lifestyle diseases' such as type 2 diabetes, and coronary heart disease.
Comment: In most cases, exercise prescription is carried out by the patient's GP or physician. Occasionally, involvement of a sports and exercise medicine specialist can add value.

This article summarises current knowledge in a succinct fashion.

Respiratory System

26-248 Managing respiratory effects of air pollution

Watson BK, Sheppeard V. Aust Fam Physician. December 2005. Vol.34. No.12. p.1033-6.
Reviewed by Dr Rachel Monk

Review: 'Air pollution is a major public health concern'. This article highlights major pollutants, overall health effects and certain vulnerable groups. It also offers tips on how this knowledge will influence patient management.

26-249 Chronic obstructive pulmonary disease: diagnostic considerations

Dewar M, Curry RW. Am Fam Physician. 15 February 2006. Vol.73. No.4. p.669-76.
Reviewed by Dr Andrea Steinberg

Review: This is a comprehensive overview of COPD, which is a heterogeneous disorder that encompasses traditional clinical entities such as emphysema and chronic bronchitis. The Global Initiative for Chronic Obstructive Lung Disease (GOLD) defines COPD as a usually progressive disease with airflow limitation that is not fully reversible and that is associated with an abnormal inflammatory response of the lungs to noxious particles or gases. Pathophysiology, signs and symptoms are discussed in detail, including the diagnostic value of spirometry. Signs and symptoms are not enough to make the diagnosis of COPD. (See also editorial 26-250)

Comment: This is a useful review of diagnosis and investigation of COPD. There is a world-wide drive to standardise management, as this is an enormous health problem. Patient handout is attached.

26-250 Using COPD guidelines to improve patient care

Heffner JE. Am Fam Physician. 15 February 2006. Vol.73. No.4. p.590-1.
Reviewed by Dr Andrea Steinberg

Review: See 26-249.

Smoking

26-251 Role of the general practitioner in smoking cessation

Zwar NA, Richmond RL. Drug Alcohol Rev. January 2006. Vol.25. No.1. p.21-6.
Reviewed by Dr Helen Moriarty

Review: A paper from NSW, Australia, which refers to USA and UK research. This review article points out that GPs see the majority of smokers at least once a year, and it asks what the barriers might be to GP-based delivery of smoking cessation advice. Education and support for staff and access and integration of services for patients are key.

Comment: This paper makes reference to smoking cessation guidelines and recommends support for implementation. Sadly it does not mention the NZ Quitline service.

26-252 Developments in pharmacotherapy for tobacco dependence: past, present and future

Foulds J, Steinberg MB, Williams JM, et al. Drug Alcohol Rev. January 2006. Vol.25. No.1. p.59-71.
Reviewed by Dr Helen Moriarty

Review: Treatments for tobacco smoking cessation have become available in the past 30 years. This paper summarises the nicotine-based and non- nicotine pharmacotherapies. Remaining knowledge gaps include: 'real-world' versus research condition responses, and efficacy and safety for pregnancy, youth and special circumstances such as psychiatric comorbidity.

Comment: Tables 1, 2 and 3 are useful for their summary comparisons of available pharmacotherapies.

26-253 Smoking cessation and depression: current knowledge and future directions

Wilhelm K, Wedgwood L, Niven H, et al. Drug Alcohol Rev. January 2006. Vol.25. No.1. p.97-107.
Reviewed by Dr Helen Moriarty

Review: A review of literature about comorbidites of smoking and depression. The 'co-dependency' of depression and smoking occurs in 22%–61% of smokers. Smoking is a major correlate of DSM IV major depression diagnosis. Aetiological models includes smoking and depression as primary; both as self-reinforcing behaviours; both caused by shared common factors. Treatments should therefore be tailored for the type of depression and the anticipated interaction as one comorbidity improves. Cochrane reviews have shown anxiolytics and exercise programmes to be ineffective. This is a field ripe for further research.

26-254 Patterns of global tobacco use in young people and implications for future chronic disease burden in adults

Warren CW, Jones NR, Eriksen MP, et al. Lancet. 4 March 2006. Vol.367. No.9512. p.749-53.
Reviewed by Dr Tony Hanne

Review: About 750 000 young people between 13–15 years in 132 countries covering all continents were surveyed about their present and likely future use of tobacco. The results were depressing. Nearly 20% were already using, and close to another 20% thought it was quite likely that they would do so in the next 12 months. Use worldwide was similar, but higher in the Americas. Use among girls was not far behind that in boys. Ways of using tobacco other than cigarettes were slightly greater. More than half were exposed to second hand smoking at home or in public places.

Comment: The worldwide death rate from effects of tobacco is expected to double to 10 million in the next 15 years. We are not doing well. Do we in our practices know the current smoking status of our patients from 13 upwards?

26-255 Secret science: tobacco industry research on smoking behaviour and cigarette toxicity

Hammond D, Collishaw NE, Callard C. Lancet. 4 March 2006. Vol.367. No.9512. p.781-7.
Reviewed by Dr Tony Hanne

Review: Perhaps the most useful outcome of litigation against tobacco companies in the US has been the forced disclosure of the results of research done by the tobacco company scientists between the late 60s and the 90s. What continues to emerge is the skill and cunning, which went into hiding much of the truth about the effects of smoking and circumventing attempts by government bodies to regulate. What was realised by these researchers and their masters is that smokers change their smoking behaviour to achieve what they want out of smoking, an adequate yield of nicotine. Ways were found to have products, which gave smokers what they sought but at the same time seemed to be meeting regulations. Cigarettes were designed, for example, to give much more to the smoker than they delivered to the testing machine.
Comment: Why are we putting so much resource into busting gang operated P labs and putting their owners behind bars for many years while at the same time tolerating a far more damaging conspiracy to deceive and destroy our young people?

Sports and Sports Medicine

26-256 Gene therapy in sport

Trent RJ, Alexander IE. Br J Sports Med. January 2006. Vol.40. No.1. p.4-5.
Reviewed by Dr Chris Milne
Review: Gene therapy has been found to be of value in conditions such as muscular dystrophy, muscle atrophy induced by space travel, and rheumatoid arthritis. These potential benefits are counterbalanced by the potential for gene doping.
Comment: Gene therapy is regarded as the 'Pandora's box' by sports doping experts. This article provides a good summary of the current and potential applications of gene therapy.

26-257 Acute weight loss followed by an aggressive nutritional recovery strategy has little impact on on-water rowing performance

Slater G, Rice AJ, Tanner R, et al. Br J Sports Med. January 2006. Vol.40. No.1. p.55-9.
Reviewed by Dr Chris Milne
Review: Lightweight rowers have been thought to be at risk of impaired performance with acute weight loss strategies employed in the lead up to major events. This study proves that any detrimental effects of weight loss can be minimised by aggressive nutritional recovery strategies in the two hour recovery period between weigh in and racing.
Comment: A useful article, worth passing onto any lightweight rowers that may be your patients.

26-258 No cumulative effects for one or two previous concussions

Iverson GL, Brooks BL, Lovell MR, et al. Br J Sports Med. January 2006. Vol.40. No.1. p.72-5.
Reviewed by Dr Chris Milne
Review: 867 male high school and university athletes were analysed with ImPACT computer-assisted concussion tests. There was no measurable effect of one or two previous concussions on athletes' test performance or symptom reporting.
Comment: This is useful knowledge, as not many of the equivalent patients in NZ have access to this type of testing.

26-259 Exercise associated hyponatraemia: quantitative analysis to understand the aetiology

Montain, SJ, Cheuvront SN, Sawka MN. Br J Sports Med. February 2006. Vol.40. No.2. p.98-106.
Reviewed by Dr Chris Milne
Review: These authors use a mathematical model to predict how plasma sodium concentration changes with time. Fluid overload appears to be the prime pathogenic factor in exercise related hyponatraemia. However, heredity, and the state of acclimatisation also play a part. Those who produce concentrated sweat, have a high sweat rate and are of low body mass are at special risk.
Comment: A very useful addition to the current knowledge.

26-260 Dose-response relation between physical activity and sick leave

Proper KI, van den Heuvel SG, De Vroome EM, et al. Br J Sports Med. February 2006. Vol.40. No.2. p.173-8.
Reviewed by Dr Chris Milne
Review: These authors analysed three large Dutch databases. They found that physical activity at a vigorous intensity level at least three times per week reduced the amount of sick leave taken.
Comment: It's nice to have this proven, even if it is what one might expect from first principles.

26-261 Effectiveness of post-match recovery strategies in rugby players

Gill ND, Beaven CM, Cook C. Br J Sports Med. March 2006. Vol.40. No.3. p.260-3.
Reviewed by Dr Chris Milne
Review: Rugby is known to induce structural damage to muscle cells, with a rise in CK enzyme levels. This study found that low impact exercise, wearing compression garments, or using hot and cold contrast baths all resulted in more rapid clearance of CK in 23 elite male rugby players, when compared to passive recovery.
Comment: This study adds to our knowledge of optimal post-game recovery strategies.

Therapeutics

26-262 Probiotics: some evidence of their effectiveness

Reid G, Hammond J-A. Can Fam Physician Med Fam Can. November 2005. Vol.51. p.1487-93.
Reviewed by Dr Mike Lyons
Review: Balanced article by doctors (one a professor of microbiology and immunology, the other a family practitioner and assistant professor in the Department of Family Medicine) at the Canadian Research and Development Centre for

Probiotics, in London, Ontario. Probiotics are live organisms, that, when given in adequate amounts confer a health benefit on the host. Lactobacillus rhamnosus GR-1 and Lactobacillus reuteri RC-14 have level 1 evidence of effectiveness in the treatment of diarrhoea. VSL#3 has the same evidence in ameliorating pouchitis and Crohn's disease. Evidence is lacking for irritable bowel syndrome. Studies on treating vaginitis are more supported than treating UTIs in females. GPs are cautioned to learn about examining labels for strain speciation, designation and shelf-life and about clinically proven strain of probiotics to feel comfortable recommending suitable probiotic supplements.

Comment: Sensible article to keep one-step ahead of our patients who trawl the net.

Urology

26-263 Medications and green urine

Gillett MJ, Burnett JR. Intern Med J. January 2006. Vol.36. No.1. p.64-6.

Reviewed by Dr Helen Moriarty

Review: Two case studies are presented, and also two colour photos of urine that would alarm most patients. This letter to the editor includes a list of drugs and food dyes known to cause green urine.

Virus Diseases

26-264 Herpes simplex virus serology in an asymptomatic patient

Sheary B, Dayan L. Aust Fam Physician. December 2005. Vol.34. No.12. p.1043-6.

Reviewed by Dr Rachel Monk

Review: This article discusses HSV serology and its interpretation.

Comment: Its role in testing asymptomatic patients is limited. However, I found this a very good reminder article on HSV and testing for it.

Instructions for authors

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

Manuscripts

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

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

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Illustrations

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

Competing interests

All authors will be asked to declare competing interests.

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