Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed In this Issue

Ann Emerg Med*
Ann Intern Med *
Aust N Z J Public Health *
Br J Sports Med*
Can Fam Physician Med Fam Can*
Evidence-Based Medicine*
Homeopathy*
Intern Med J*
J Fam Pract*
J Med Screen*
Lancet*
Physician and Sportsmedicine*
Postgrad Med*
Sci Am*
*Journals indexed in Medline

Alternative Medicine

22-330 The risk-benefit profile of commonly used herbal therapies: Ginkgo, St. John's Wort, Ginseng, Echinacea, Saw Palmetto, and Kava.

Ernst, E. Ann Intern Med. 1 January 2002. Vol.136. No.1. p.42-53.

Reviewed by Dr Mike Slatter

Review: Clinically oriented overview of efficacy and safety of current best-selling herbal medicinal products. Discussion is based on systematic reviews of randomised clinical trials.

Comment: Authoritative review of these commonly used herbal remedies. A good resource to refer to especially regarding efficacy, safety, dosage and drug interactions. Discusses deficiencies in herbal medical products including lack of quality control and standardisation. The public perceive these products to be devoid of adverse effects which is not true. Several books are recommended for a professional readership.

Cardiovascular System

22-331 Can a simple warfarin initiation scheme predict the maintenance dose in patients with nonrheumatic atrial fibrillation?

Culhane NS. J Fam Pract. February 2002. Vol.51. No.2. p.175.

Reviewed by Dr Bruce Adlam

Review: Answer = Yes. Starting outpatients with 5 mg per day of warfarin and basing a maintenance dose on the INR obtained on the fifth day is an effective way to initiate therapy. The difference between the actual and predicted maintenance doses was small. (Original article reviewed: Am J Cardiol; 88: 1214-6).

22-332 Glucose metabolism in patients with acute myocardial infarction and no previous diagnosis of diabetes mellitus: a prospective study.

Norhammar A, Tenerz A, Nilsson G, et al. Lancet. 22 June 2002. Vol.359. No.9324. p.2140-4.

Reviewed by Dr Tony Hanne

Review: In a group of 181 patients admitted to a coronary care unit in Sweden with no previous diagnosis of diabetes who were then carefully screened, about a third were shown to be diabetic and another third to have impaired glucose tolerance. The screening process included fasting and postprandial blood glucose, HbA1c and oral glucose tolerance tests initially and after three months.

Comment: The increased risk of myocardial infarction in diabetics is well known. What is a surprise is the level of risk in those having only impaired tolerance. This study gives further impetus to the careful search for even early diabetes.

journal review service

Continuing Medical Education in General Practice from the Goodfellow Unit

About JRS

Copies of articles reviewed in the Journal Review Service (JRS) may be ordered by completing the yellow, free postage mailing slip found in this journal. Please quote the review numbers (e.g. 21–095) for the articles you order. If the mailing slip has been used then please send a letter to the address below. We do require a return postal address.

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

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

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

The Goodfellow Unit, Faculty of Medicine and Health Sciences, The University of Auckland, would especially like to thank the reviewers and their staff for the time they generously give to the JRS. We would also like to thank the Philson Library (who supply the reprint service), the RNZCGP, and the other sponsors of the JRS.

JRS Reviewers

Reviewers are required for the JRS. Please write giving details to:
Dennis Kerins, Goodfellow Unit
Faculty of Medical & Health Sciences
University Private Bag 92019
Auckland, New Zealand

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

22-333 Carvediolol reduced mortality and hospitalisation in severe chronic heart failure.

Rao G. Evidence-Based Medicine. November/December 2001. Vol.6. No.6. p.173.
Reviewed by Dr Bruce Arroll

Review: The patients in this study had to have dyspnoea or fatigue at rest or on minimal exertion for more than two months and have an ejection fraction of less than 25%. The relative risk reduction for death was 35% and for death and hospitalisation 24%. NNT 15 and 10 respectively. (Original article reviewed: N Engl J Med 2001 May 31; 344: 1651-8)
Comment: Carvedilol has recently become available in New Zealand and should be considered for patients whose heart failure has worsened either on or off other beta blockers. Gradual increase in the dose up to 25mg BD is recommended. Carvedilol was listed in the New Zealand Pharmaceutical Schedule on 1st April 2002 with the following indications: a) Approved where patients are already on an ACE inhibitor or Angiotensin II Antagonist with; (1) Symptomatic heart failure NYHA functional class II-III who have been treated with metoprolol and are intolerant to metoprolol or have demonstrated a sub-optimal response to metoprolol; OR (2) Symptomatic heart failure NYHA functional class III-IV or left ventricular systolic dysfunction with an ejection fraction of less than 35%.

22-334 Gemfibrozil reduced the risk for stroke in men with coronary heart disease and low concentrations of high-density lipoprotein cholesterol.

Donnan GA. Evidence-Based Medicine. November/December 2001. Vol.6. No.6. p.175.
Reviewed by Dr Bruce Arroll

Review: This study found a reduction in the number of ischaemic strokes in patients with an HDL of < 1.03 mmol/l, LDL < 3.6 and triglycerides < 3.39 mmol/l. There was no difference in fatal strokes. (Original article reviewed: Circulation 2001 Jun; 103: 2828-33)
Comment: The commentator made the point that this is the first study to show a reduction in strokes for a fibrate. There is also evidence that statins will also lower the incidence of stroke. So far there are no comparative studies of statin versus fibrate and no studies of the two combined. The good news is that this gives us additional ammunition to stave off the consequences of atherosclerosis.

22-335 Screening for ischaemic heart disease by serum homocysteine measurement.

J Med Screen. December 2001. Vol.8. No.4. p.220.
Reviewed by Dr Bruce Arroll

Review: This article appears in the section known as 'screening brief'. It points out that screening for IHD based on homocysteine measurement is not justified. This does not mean that treating high homocysteine levels with folic acid will not prove to be beneficial.
Comment: We need to wait for the trials of folic acid versus placebo on IHD.

22-336 Aspirin for the primary prevention of cardiovascular events: recommendation and rationale.

U.S. Preventive Services Task Force. Ann Intern Med. 15 January 2002. Vol.136. No.2. p.157-60.
Reviewed by Dr Mike Slatter

Review: This clinical guideline summarises the recommendations of the US Preventive Services Task Force (USPSTF) for Aspirin for the primary prevention of cardiovascular events.
Comment: The role of Aspirin in primary prevention of coronary heart disease has been controversial. This guideline or recommendation strongly recommends Aspirin prophylaxis for those at high risk of coronary heart disease (five yr risk > 3%). Valid new recommendations for our patients at high risk of developing coronary artery disease.

22-337 Atherosclerosis: the new view.

Libby P. Sci Am. May 2002. Vol.286. No.5. p.28-37.
Reviewed by Dr Ron Vautier

Review: At high concentrations, LDL particles accumulate in the arterial intima and undergo oxidation and glycation, triggering an inflammatory response which results in plaque formation, and sometimes plaque rupture and thrombosis. Diabetes, smoking, hypertension and perhaps infection, potentiate the inflammation. A raised c-reactive protein may be a significant risk factor.
Comment: I give this article the highest possible recommendation.

22-338 In patients with diabetes and hypertension, should treatment start with an ACE inhibitor instead of a diuretic or beta blocker?

Mackrides PS, Shaughnessy AF. J Fam Pract. March 2002. Vol.51. No.3. p.203.
Reviewed by Dr Bruce Adlam

Review: About half of all patients with type 2 diabetes will eventually die because of a cardiovascular disease-related event. The primary outcome of fatal and nonfatal MI and stroke, as well as that of other cardiovascular deaths, was significantly lower in the Captopril treated group than in the conventional treatment group (RR = 0.59, 95% CI 0.38-0.91, number needed to treat [NNT] = 16). This study suggests Captopril may be the initial agent of choice for hypertension in diabetic hypertensive patients, especially those with poor glycaemic or lipid control. Captopril was shown to reduce overall mortality, MI risk, and overall cardiac events significantly better than did treatment initiated with either a diuretic agent or a beta blocker (Original article reviewed: Diabetes Care 2001; 24: 2091-6)

22-339 Should antioxidants be added to simvastatin and niacin for patients with coronary disease?

Burgert W III, Newton WP. J Fam Pract. March 2002. Vol.51. No.3. p.208.

Reviewed by Dr Bruce Adlam

Review: Antioxidant vitamins are commonly used in patients with coronary disease, but benefits have not been demonstrated. This well-designed study provides strong evidence that antioxidants should not be used in patients with pre-existing coronary disease, either alone or in addition to simvastatin and niacin. The combination of a statin and niacin reduced adverse cardiac events dramatically in this population with low LDL cholesterol levels. Patients receiving simvastatin-niacin had significantly fewer cardiovascular events than those given placebo (21% vs 2.6%, P = .003, number needed to treat = 4.7). Addition of antioxidants actually blunted this effect: when antioxidant therapy was added to lipid lowering, the rate of clinical events increased to that observed with placebo. (Original article reviewed: N Engl J Med 2001; 345: 1583-91).

22-340 Diagnosing heart failure: Are blood tests an option for primary care?

Hobbs FD. J Fam Pract. March 2002. Vol.51. No.3. p.262.

Reviewed by Dr Bruce Adlam

Review: This is from the '2001 Meeting of the North American Primary Care Research Group': Abstracts of distinguished papers.

Comment: S BNP and NT-proBNP have value in the diagnosis of heart failure in a community setting.

22-341 Do whole-grain oat cereals reduce the need for antihypertensive medications and improve blood pressure control?

Pins JJ, Geleva D, Keenan JM, et al. J Fam Pract. April 2002. Vol.51. No.4. p.353-9.

Reviewed by Dr Bruce Adlam

Review: This small (n=88) 12-week, randomised controlled parallel-group trial compared two whole grain oat-based cereals with two refined grain wheat-based cereals to determine their effects on the need for antihypertensive medications in people with high blood pressure (BP). Results suggest that a diet containing soluble fibre-rich whole oats can significantly reduce the need for antihypertensive medication and improve BP control.

Comment: Considering the lipid and glucose improvements as well, increased consumption of whole oats may significantly reduce cardiovascular disease risk.

22-342 Weekly versus daily dosing of atorvastatin.

Iliff RD. J Fam Pract. April 2002. Vol.51. No.4. p.365-6.

Reviewed by Dr Bruce Adlam

Review: Twenty-four consecutive patients of a single family physician who had achieved NCEP-II goal levels of low-density lipoprotein cholesterol (LDL-C) on a daily atorvastatin dose of 10 mg for at least six months were invited to switch to 20 mg weekly. Mean LDL levels for the 22 patients who completed the trial had been reduced by 43% from baseline on 10 mg daily (P < .05) and were reduced by 22% from baseline on the seventh day following the last weekly dose of 20 mg (P < .05). Total cholesterol to high-density lipoprotein cholesterol (TC/HDL-C) ratios were reduced by 31% and 17%, respectively (both P < .05) and triglycerides by 20% and 10% (both P < .05).

Comment: With pharmaceutical costs leading medical inflation, a current challenge for clinicians is to alter the cost-benefit ratio of prescriptions to the advantage of patients. Weekly dosing, as has recently been approved for alendronate sodium (Fosamax) and fluoxetine hydrochloride (Prozac), is one approach to this problem. In this preliminary study, weekly dosing of 20 mg atorvastatin resulted in a 22% reduction of LDL-C, measured on the seventh day after dosing. This regimen represents an approximately 80% reduction in yearly cost compared with that of a regimen of 10 mg daily. Since this study did not investigate the pattern of LDL-C reduction in the interval between doses, further research is needed to delineate the area under the curve and the impact on clinical outcomes before conclusions may be drawn regarding the effectiveness of weekly dosing.

22-343 Treatment of hyperlipidemia.

Henley E, Chang L, Hollander S. J Fam Pract. April 2002. Vol.51. No.4. p.370-6.

Reviewed by Dr Bruce Adlam

Review: This is a key article on treatment of hyperlipidaemia addressing issues of when to treat and what to treat with. Statins emerge as key treatment for those indicated by guidelines and their profile as a safe and effective, although costly, therapy for hyperlipidaemia and the development of clinical guidelines advocating their increased use will place family physicians under added pressure to screen for and treat hyperlipidaemia.

Communication

22-344 Communicating in a multicultural society II: Greek community attitudes towards cancer in Australia.

Goldstein D, Thewes B, Butow P. Intern Med J. July 2002. Vol.32. No.7. p.289-96.
Reviewed by Dr Helen Moriarty
Review: This is an Australian paper, but don't let that put you off reading it. This gives insight into cultural awareness issues for cultures other than our indigenous and PI peoples. To the Greek, having cancer is a source of shame.
Comment: Themes in this paper will assist the reader to think more about culturally appropriate communication.

Emergency Medicine

22-345 Clinical policy: critical issues in the evaluation and management of patients presenting with syncope.

American College of Emergency Physicians. Ann Emerg Med. June 2001. Vol.37. No.6. p.771-6.
Reviewed by Dr Mike Slatter
Review: This policy is a production of the American College of Emergency Physician's policy development process which includes expert review of existing literature and the consensus of an expert panel.
Comment: Addresses the issue of risk stratification and who should be admitted to hospital after a syncopal event. Very good article pointing to important features in the history and examination, and clear recommendations on who to refer to hospital after syncope.

22-346 Validation of the Ottawa Knee Rules.

Emparanza JI, Aginaga JR. Ann Emerg Med. October 2001. Vol.38. No.4. p.364-8.
Reviewed by Dr Mike Slatter
Review: A prospective cohort study from Spain found the Ottawa Knee Rules to be 100% sensitive for fracture of the knee.
Comment: Good study confirming the usefulness of the Ottawa Knee Rules as a clinical prediction instrument. Important to know these rules when deciding on whether to x-ray an injured knee.

22-347 Finding truths in clinical medicine: through the looking glass - cracked.

Schriger DL. Ann Emerg Med. November 2001. Vol.38. No.5. p.566-9.
Reviewed by Dr Mike Slatter
Review: This editorial examines in some depth the concept of structured reviews and how we should judge them (quality scoring). Also looks at how we cope with uncertainty. (See also 22-348)
Comment: Looks at the usefulness of the structured review (the in-vogue method for divining truth). The point is made that structured reviews are not the wonderful solution that some evidence-based medicine advocates suggest. This is a lesson in bias.

22-348 Evaluating the quality of systematic reviews in the emergency medicine literature.

Kelly KD, Travers A, Dorgan M, et al. Ann Emerg Med. November 2001. Vol.38. No.5. p.518-26.
Reviewed by Dr Mike Slatter
Review: See 22-347.

22-349 Polypharmacy, adverse drug-related events, and potential adverse drug interactions in elderly patients presenting to an emergency department.

Hohl CM, Dankoff J, Colacone A, et al. Ann Emerg Med. December 2001. Vol.38. No.6. p.666-71.
Reviewed by Dr Mike Slatter
Review: A retrospective chart review looking at ADREs and PADIs in patients 65 years and older who attended an ED. Ten per cent of ED presentations in this age group were found to be due to ADREs. The average number of medications per patient was 4.2.
Comment: This study serves to deliniate the importance of ADREs in elderly patients. Lists the common offending medications and lists the presentations that should alert one to a possible ADRE.

22-350 Clinical policy: critical issues in the evaluation and management of patients presenting to the emergency department with acute headache.

American College of Emergency Physicians. Ann Emerg Med. January 2002. Vol.39. No.1. p.108-22.
Reviewed by Dr Mike Slatter
Review: Clinical policy focusing on critical issues in evaluation and management of patients with acute headache. It builds on a previous clinical policy developed and published in the same journal - June 1996. It excludes headaches from trauma/injury.
Comment: Acute headache is a common complaint in general practice and A&M clinics. This article helps one approach headache from an 'ED perspective' which is important in helping us to not miss critical aetiologies that require rapid identification and intervention. Has good advice on who needs emergent or urgent CT scans.

22-351 Persistence of delays in presentation and treatment for patients with acute myocardial infarction: The GUSTO-I and GUSTO-III experience.

Gibler WB, Armstrong PW, Ohman EM, et al. Ann Emerg Med. February 2002. Vol.39. No.2. p.123-30.
Reviewed by Dr Mike Slatter
Review: This article examines delays to hospital arrival and treatment in these two large trials of fibrinolytic therapy. In hospital time to treatment had decreased but time to arrival had not changed over the past seven years. The elderly, women, diabetics and minorities were more likely to exhibit delays in hospitalisation. (See also the editorial 22-352)
Comment: This article helps us to keep focused on our patients with chest pain. They need urgent assessment and referral on with haste if there is any suspicion of coronary ischaemia.

22-352 Cardiology and emergency medicine: United we stand, divided we fall.

Gibler WB, Topol EJ, Holroyd B, et al. Ann Emerg Med. February 2002. Vol.39. No.2. p.164-7.
Reviewed by Dr Mike Slatter
Review: See 22-351.

Endocrinology

22-353 Continuity of care, stages of change for self-management behaviors, and glucose control among patients with type 2 diabetes.

Parchman ML, Solomon T, Noel PH, et al. J Fam Pract. March 2002. Vol.51. No.3. p.263-4.
Reviewed by Dr Bruce Adlam

Review: This is from the '2001 Meeting of the North American Primary Care Research Group': Abstracts of distinguished papers.

Comment: Continuity of care is associated with improved glucose control. A significant amount of this relationship is mediated by advancement in stage of change for diet.

22-354 Which oral antihyperglycemics are most efficacious in reducing hemoglobin A1C in diabetic patients?

Abrahamson L, Newton W. J Fam Pract. April 2002. Vol.51. No.4. p.311.
Reviewed by Dr Bruce Adlam

Review: Despite the claims of pharmaceutical marketing, there is little difference among sulfonylureas, metformin, and thiazolidinediones in reduction of haemoglobin A1C. Each class achieves an average reduction of 1% to 2%. Alpha glucosidase inhibitors and nonsulfonylurea secretogogues are probably somewhat less efficacious; combinations of medications seem to be additive. (Original article reviewed: JAMA 2002; 287: 360-72.)

Comment: Their recommendation is that clinicians should keep in mind that diet and exercise remain first-line treatment for type 2 diabetes. To date, only metformin and sulfonylureas have been shown to be beneficial in reducing microvascular complications. Only metformin has been shown to reduce macrovascular complications and all cause mortality in obese patients with type 2 diabetes. Interestingly, this beneficial effect of metformin is totally independent of blood sugar control. Thus, metformin should be the pharmaceutical agent of first choice in the treatment of type 2 diabetes.

22-355 Oral agents for the treatment of type 2 diabetes mellitus: Pharmacology, toxicity, and treatment.

Harrigan RA, Nathan MS, Beattie P. Ann Emerg Med. July 2001. Vol.38. No.1. p.68-78.
Reviewed by Dr Bruce Adlam

Review: This review article examines currently available oral antidiabetic drugs (pharmacology, adverse effects, toxicities). It also describes treatment for sulfonylurea-induced hypoglycaemia.

Comment: Discusses strategies for glycaemic control and causes of treatment failure in type 2 diabetes. Good coverage of Sulphonylureas and Biguanides. Important reading in keeping up to date in diabetes management.

Family Practice

22-356 Where have Canada's general practitioners gone?

Kondro W. Lancet. 22 June 2002. Vol.359. No.9324. p.2175.
Reviewed by Dr Tony Hanne

Review: A study looked at why GP numbers in Canada were declining. The causes in order of importance were: a longer postgraduate training period being required, restriction on foreign trained doctors, rising rates of retirement, reduced medical school enrolments, emigration to the US and the greater ratio of female graduates.

Comment: The longer period of GP training had the effect of greatly reducing the likelihood that new medical graduates would ever have a taste of general practice. The need to ask the same questions in NZ is even more pressing that it is in Canada.

Gastroenterology

22-357 Upper gastrointestinal endoscopic ultrasound and its impact on patient management: 1990-2000.

Kaffes AJ, Mishra A, Simpson SB, et al. Intern Med J. August 2002. Vol.32. No.8. p.372-8.
Reviewed by Dr Helen Moriarty

Review: This is a new method of GI tract investigation. The team at Concord, NSW, did a retrospective review of indications, safety etc. and audited for impact on case management. Endoscopic ultrasound (EUS) avoids invasive procedures, can guide fine needle aspiration biopsy (FNAB), and is 76% accurate compared to a histological confirmation.

Comment: There are many situations where EUS is useful – staging cancers, oesophageal or gastric mucosal lesions, etc. It is now available at major hospitals.

General

22-358 Patient perspectives on the Doctor of the future.

Main DS, Tressler C, Staudenmaier A, et al. J Fam Pract. March 2002. Vol.51. No.3. p.262.
Reviewed by Dr Bruce Adlam

Review: This is from the '2001 Meeting of the North American Primary Care Research Group': Abstracts of distinguished papers.

Comment: Patient perspectives of the doctor of the future should be considered in decisions about health care reform, a patient's bill of rights, and the content of medical school curriculum.

22-359 Feminism and medicine.

Rothfield P. Intern Med J. July 2002. Vol.32. No.7. p.320-1.
Reviewed by Dr Helen Moriarty

Review: A short pithy article discussing feminism, its impact on practice of medicine, and the impact of medicine on feminism. It concludes that feminism can assist in understanding of gender, identity and sexuality in biomedicine.

Genetics

22-360 The magic of microarrays.

Friend SH, Stoughton RB. Sci Am. February 2002. Vol.286. No.2. p.34-41.
Reviewed by Dr Ron Vautier

Review: It is a bit like DNA profiling, and is used to determine which genes are active in given situations. Besides

leading to a better understanding of pathology at a molecular level this technology is expected to lead to more individualised drug therapy.
Comment: An easily comprehended and fairly brief look at an area that practitioners might expect to have some knowledge of in a few years when application becomes more routine.

22-361 The human genome project and genome variation.
Cotton RG. Intern Med J. July 2002. Vol.32. No.7. p.285-8.
Reviewed by Dr Helen Moriarty
Review: An easy-to-read article about the impact of genome mapping on disease identification, and on the new arenas of genome-wide studies - the 'omics'. The full extent of polymorphism and pathogenic mutations even in single gene disorders is now becoming apparent.
Comment: The task of gene sequencing is by no means 'completed'.

Guidelines

22-362 Evaluating the efficacy of vaccine storage in the general practice setting.
Lewis PR, Reimer RF, Dixon AJ. Aust N Z J Public Health. December 2001. Vol.25. No.6. p.547-50.
Reviewed by Dr Bruce Arroll
Review: This study was a survey of general practices in the central New South Wales region. Their findings were that a quarter of fridges were freezing (i.e. <0 degrees centigrade) in spite of improvements in vaccine storage practices.
Comment: The key points of vaccine storage are to maintain temperature between two and eight degrees centigrade, have one person responsible for the vaccine storage, fridge temperature checked daily, no other items stored in the fridge and to have a thermometer on the fridge.

Gynaecology

22-363 Just the berries: who needs an endometrial biopsy?
Samson S-L, Gilmour D. Can Fam Physician Med Fam Can. May 2002. Vol.48. p.885-7.
Reviewed by Dr Mike Lyons
Review: This article is from the clinical challenge series 'to provide useful, practical and current information to busy family physicians'. Covers most of what we need to know in three pages.
Comment: Mission accomplished! Other 'berries' at www.theberries.ns.ca

22-364 Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50 302 women with breast cancer and 96 973 women without the disease.
Collaborative Group on Hormonal Factors in Breast Cancer. Lancet. 20 July 2002. Vol.360. No.9328. p.187-95.
Reviewed by Dr Tony Hanne
Review: It has long been clear that childbearing has a protective effect against breast cancer but it had not been established whether and to what extent breastfeeding separately protects. According to this meta-analysis the risk of breast cancer is reduced by 4.3% for each 12 months of breastfeeding and by 7% for each birth. If women breast fed to the extent they used to until comparatively recently the overall risk of breast cancer would be reduced from 6.3 to 2.7 per 100 women by age 70.
Comment: While breastfeeding is socially approved at the present time, continuing beyond 12 months is commonly regarded as somewhat comic. This attitude needs to change. The demand to return to work early is equally damaging.

Homeopathy

22-365 Homeopathic treatment of hot flushes: a pilot study.
Clover A, Ratsey D. Homeopathy. April 2002. Vol.91. No.2. p.75-9.
Reviewed by Dr Mimi Irwin
Review: This report documents the outcomes of using homeopathy for the treatment of hot flushes. It is uncontrolled and studied 31 patients who were referred to Tunbridge Wells Homeopathic Hospital. Hot flushes were graded for frequency and severity and the group consisted of women with hot flushes, and no breast cancer as well as those with breast cancer with or without Tamoxifen. Assessment of benefit from homeopathy was made by both the patient and the doctor separately.
Comment: This is a small uncontrolled audit of practice. Seventy-three per cent of patients reported a useful improvement in their symptoms overall. Those on Tamoxifen had less benefit. The six most frequently prescribed medicines were: Amyl nitrosum, Calc carb., Lachesis, Natrum mur, Pulsatilla and Sepia. It would be of great interest to see the results from a larger and controlled study.

Immunology and Allergy

22-366 Which is more effective for as-needed treatment of seasonal allergy symptoms: intranasal corticosteroids or oral antihistamines?
Frantz J. J Fam Pract. March 2002. Vol.51. No.3. p.281.
Reviewed by Dr Bruce Adlam
Review: Small study of 88 people comparing loratidine (not as effective as other non sedating antihistamines) and fluticasone. It was also not blinded so for what it's worth this study shows that for as-needed treatment of allergic rhinitis, fluticasone propionate appears to be superior to loratadine in both subjective and objective measurements. (Original article reviewed: Arch Intern Med 2001; 161: 2581-7)

22-367 Anaphylaxis and anaphylactoid reactions: A guide to prevention, recognition, and emergent treatment.
Rusznak C, Peebles RS Jr. Postgrad Med. May 2002. Vol.111. No.5. p.101-14.
Reviewed by Dr Chris Milne
Review: Common causes include food (peanuts), insect stings, medications, latex and exercise. Treatment includes adrenaline (epinephrine), oxy-

gen, B2 agonist, antihistamines and corticosteroids. Provision of an auto-injectable adrenaline delivery device (e.g. Ana-kit or EpiPen) is highly recommended. Make sure patients and their care givers or associates know how to use it.
Comment: Useful update on an important topic.

Musculoskeletal System

22-368 Which is most effective for osteoarthritis of the knee: rofecoxib, celecoxib, or acetaminophen?

Saseen JJ. J Fam Pract. April 2002. Vol.51. No.4. p.307.
Reviewed by Dr Bruce Adlam
Review: In this study, 25 mg rofecoxib once daily was more effective than either celecoxib or acetaminophen in relieving persistent pain and stiffness from knee OA. However, only one of six patients taking acetaminophen, which is inexpensive and safe, discontinued treatment for lack of efficacy. Therefore, using acetaminophen as first-line therapy is reasonable. Less expensive traditional NSAIDs (e.g. ibuprofen or naproxen) have been shown to have similar effectiveness as compared with either rofecoxib or celecoxib in OA. For patients at low risk for serious NSAID-associated gastrointestinal complications, traditional NSAIDs should be the next agents of choice. For patients at high risk, COX-2 selective inhibitors are reasonable second-line agents, since they pose a lower risk of NSAID-associated gastrointestinal complications with long-term use. (Original article reviewed: JAMA 2002; 287: 64-71)

Neurology

22-369 Scars that won't heal: the neurobiology of child abuse.

Teicher MH. Sci Am. March 2002. Vol.286. No.3. p.54-61.
Reviewed by Dr Ron Vautier
Review: Physiological, anatomical, and biochemical differences from normal are identifiable in the brains, especially the limbic regions of psychiatric patients who have been physically and emotionally maltreated as young children.
Comment: While these findings are somewhat controversial, they suggest that reprogramming personality disorders may be impossible. Provides good thought fodder.

22-370 The relationship between insomnia and health-related quality of life in patients with chronic illness.

Katz DA, McHorney CA. J Fam Pract. March 2002. Vol.51. No.3. p.229-35.
Reviewed by Dr Bruce Adlam
Review: The objective of this cross-sectional analysis of 3 445 patients was to determine the association between insomnia and health-related quality of life (HRQOL) in patients with chronic illness after accounting for the effects of depression, anxiety, and medical comorbidities. It found that insomnia is independently associated with worsened health-related quality of life to almost the same extent as chronic conditions such as congestive heart failure and clinical depression.
Comment: GPs now are reluctant to medicate patients for insomnia especially in the long term and there is possibly a tendency to put aside complaints of insomnia rather than assist with some of the non-drug measures that may be able to improve these patients quality of life.

22-371 Treatment patterns of isolated benign headache in US Emergency Departments.

Vinson DR. Ann Emerg Med. March 2002. Vol.39. No.3. p.215-22.
Reviewed by Dr Mike Slatter
Review: This is an analysis of 100 million ED visits by adults with isolated diagnosis of migraine headache or unspecified headache. Opioid use exceeded that of nonopioid abortive migraine medication. Findings showed poor compliance with the US and Canadian guidelines. (See also editorial 22-372)
Comment: I think the NZ General Practice and A&M clinic experience would show a similar use of opioids. Patients often have an expectation of an opioid to get relief. We should be using more dopamine-antagonist antiemetics, triptans and NSAIDs as initial agents.

22-372 Headaches from practice guidelines.

Wears RL. Ann Emerg Med. March 2002. Vol.39. No.3. p.334-7.
Reviewed by Dr Mike Slatter
Review: See 22-371.

22-373 Bacterial infection as a cause of multiple sclerosis.

Wolfson C, Talbot P. Lancet. 3 August 2002. Vol.360. No.9330. p.352-3.
Reviewed by Dr Tony Hanne
Review: The search for the cause of multiple sclerosis has been a long and frustrating journey. This commentary summarises the state of the play and some tantalising clues. Some common viruses have been implicated particularly the Epstein-Barr virus, and measles and mumps occurring later than childhood. The latest intriguing suspect is a spirochaete, Borrelia Burgdorferi. Cerebrospinal fluid has been found to be seropositive to this organism in MS patients.
Comment: It is beginning to look like multiple sclerosis may have multiple causes.

22-374 Sleep disorders: a potential role in New Zealand motor vehicle accidents.

Yee B, Campbell A, Beasley R, et al. Intern Med J. July 2002. Vol.32. No.7. p.297-304.
Reviewed by Dr Helen Moriarty
Review: Questionnaires and polysomnography studies were done on 40 injured drivers admitted to Wellington Hospital. Driver sleepiness or falling asleep accounted for 15% of the accidents. Sleep disorders were common with 36% of drivers having obstructive sleep dyspnoea.
Comment: This study had problems with recruiting, since it picked up par-

ticipants from ED Department. Non-participants differed from participants.

22-375 Measurement variability in sleep disorders medicine: the Victorian experience.

Manser RL, Rochford P, Naughton MT, et al. Intern Med J. August 2002. Vol.32. No.7. p.386-93.

Reviewed by Dr Helen Moriarty

Review: Several Melbourne sleep laboratories collaborated to interview staff about clinical practices, equipment used, and methods of measurement and definition of sleep-disordered breathing. Clinician variability was alive and well – especially on definitions of hypopnoea!

Comment: The moral of this story is to get to know your local services, and be sure you know on what basis they make diagnoses, and how comparable other local services are.

Obstetrics

22-376 Parents' prenatal to postpartum work changes and the impact of a support/work planning intervention on first-time parents' work sharing.

Gjerdingen DK, Carter B. J Fam Pract. March 2002. Vol.51. No.3. p.264.

Reviewed by Dr Bruce Adlam

Review: This is from the '2001 Meeting of the North American Primary Care Research Group': Abstracts of distinguished papers.

Comment: These new parents experienced significant expansions in their work responsibilities and less perceived household work sharing after childbirth. However, a support and work-sharing intervention improved fathers' perceived contributions to household work post-delivery.

22-377 Comparison of abortions induced by methotrexate or mifepristone followed by misoprostol.

Wiebe E, Dunn S, Guilbert E, et al. J Fam Pract. March 2002. Vol.51. No.3. p.264.

Reviewed by Dr Bruce Adlam

Review: This is from the '2001 Meeting of the North American Primary Care Research Group': Abstracts of distinguished papers.

Comment: Abortions induced with mifepristone were completed faster than those induced with methotrexate. Overall success rates, side effects, and complications were similar. Acceptance rates were slightly higher with mifepristone than with methotrexate.

22-378 Promoting postpartum exercise: An opportune time for change.

Ringdahl EN. Physician and Sportsmedicine. February 2002. Vol.30. No.2. p.31-8.

Reviewed by Dr Rob Campbell

Review: Did you know breastfeeding infants prefer pre-exercise milk compared to post exercise milk? The main thrust of this paper is that the postpartum period is an ideal time for woman to be encouraged to re establish exercise routines to manage weight, stress and lack of social contact.

Comment: A useful paper if you are getting your patients back from the midwives and they want some advice regarding exercising in the first six months post partum.

Oncology

22-379 Prediction of colorectal cancer by a patient consultation questionnaire and scoring system: a prospective study.

Selvachandran SN, Hodder RJ, Ballal MS, et al. Lancet. 27 July 2002. Vol.360. No.9329. p.278-83.

Reviewed by Dr Tony Hanne

Review: A comprehensive patient completed questionnaire was used with 2 268 patients referred to a surgical clinic because of concern about possible colorectal cancer. Responses were scored by a computer programme and used as the basis for prioritising assessment. The questionnaire proved much more reliable in predicting the 95 cancers in the group than surgeons scoring doctors' referral letters.

Comment: This study is a sad commentary on the quality of referral letters, the length of public waiting lists in the UK, and the inadequacy of existing hospital criteria for determining urgency. A significant number of the 95 cancers were eventually found in the 'low risk' group. Such questionnaires could easily be incorporated in our PMS software provided they were also accepted as referral criteria by public hospitals.

22-380 Hereditary colorectal cancer: keeping it in the family – the bowel cancer story.

McGrath DR, Spigelman AD. Intern Med J. July 2002. Vol.32. No.7. p.325-30.

Reviewed by Dr Helen Moriarty

Review: A clinical perspectives paper. Discusses the hereditary bowel cancer syndromes. Up to 20% of bowel cancers have a genetic component. Testing, surveillance, genetic markers, and management issues are covered.

Comment: A good article to read for a quick overview of this topic.

22-381 Hepatocellular carcinoma: current approaches to diagnosis and management.

McCaughan GW, Koorey DJ, Strasser SI. Intern Med J. August 2002. Vol.32. No.8. p.394-400.

Reviewed by Dr Helen Moriarty

Review: An easy-to-read overview of what is done, and why, in management of Hepatocellular carcinoma (HCC). A growing incidence of HCC is attributed to the rise in cases caused by hepatitis B virus (HBV) and hepatitis C virus (HCV).

Comment: The onus is on GPs to monitor HBV and HCV patients for markers of HCC.

Oral Health

22-382 The science of bad breath.

Rosenberg M. Sci Am. April 2002. Vol.286. No.4. p.58-65.

Reviewed by Dr Ron Vautier

Review: Halitosis is due to substances produced by bacteria living especially on the back of the tongue, and less often around the teeth and gums, in the nose, in the tonsils, and rarely elsewhere. This article includes good discussion of the associated psychosocial factors, and useful tips for dealing with the problem.
Comment: This is a useful and interesting article that GPs would do well to peruse.

Orthopaedics

22-383 Is splinting of distal radius torus fractures an acceptable alternative to casting?

Walker JK, Kane KY. J Fam Pract. April 2002. Vol.51. No.4. p.382.
Reviewed by Dr Bruce Adlam
Review: This study of 202 children showed that treating torus fractures of the distal radius with casting versus splinting has no clinical difference in outcome. Some cost saving seems to occur when torus fractures are treated with splinting rather than casting, since splinting obviates a follow-up visit for cast removal. After reading this study, we agree that Futura splinting of distal radial torus fracture for 3 weeks appears to be a reasonable alternative to casting. The absence of complications in both groups suggests that a follow-up visit and confirmatory radiologic imaging may not be necessary. (Original article reviewed: J Bone Joint Surg [Br] 2001; 83-B: 1173-5.)

Prescribing

22-384 Can a patient information sheet reduce antibiotic use in adult outpatients with acute bronchitis?

DeBisschop M, Robitaille B. J Fam Pract. April 2002. Vol.51. No.4. p.381.
Reviewed by Dr Bruce Adlam
Review: In this study, a written patient information sheet along with verbal counseling from the physician stopped one additional patient of seven from filling an antibiotic prescription of questionable necessity. There was no change in other patient outcomes. (Original article reviewed: BMJ 2002; 324: 1-6.)
Comment: This intervention can decrease the cost of therapy and, theoretically, may contribute to slowing the spread of antibiotic resistance in the community.

Primary Health Care

22-385 Patients' perceptions of the 'patient-centeredness' of doctor behavior and their relationship with outcomes.

Little P. Everitt H, Williamson I, et al. J Fam Pract. March 2002. Vol.51. No.3. p.263.
Reviewed by Dr Bruce Adlam
Review: This is from the '2001 Meeting of the North American Primary Care Research Group': Abstracts of distinguished papers.
Comment: Measurement of patients' perceptions of patient-centeredness provides a marker of quality of care.

22-386 Exercise prescriptions for active seniors: A team approach for maximizing adherence.

Brennan FH Jr. Physician and Sportsmedicine. February 2002. Vol.30. No.2. p.19-29.
Reviewed by Dr Rob Campbell
Review: The article concentrates on exercise prescription for the 60 plus age group but has much useful information relevant to all ages. It starts with the rationale and physiology, and risks of exercise including some medication issues. It then details how to plan an exercise programme.
Comment: An excellent paper. If you want to prescribe exercise or exercise yourself read this.

Psychiatry and Psychology

22-387 Review: antidepressants plus benzodiazepines lead to fewer drop outs and less depression severity in major depression.

Gijsman H. Evidence-Based Medicine. November/December 2001. Vol.6. No.6. p.184.
Reviewed by Dr Bruce Arroll
Review: This review found that up to 4 weeks after the initiation of antidepressant therapy with either tricyclics or SSRIs that there was a greater reduction of depressive symptoms and less likelihood of drop out if the patients were given a benzodiazepine. A wide range of benzodiazepines were used. (Original article reviewed: Cochrane Database Syst Rev 2000; (4): CD001026 and J Affect Disord 2001 Jul; 65: 173-7)
Comment: The commentator on this study suggests only giving benzodiazepines to patients with a high level of anxiety for a few weeks and then withdrawing them gradually.

22-388 Short scales were as effective as long scales in screening for depression in older patients.

Sherman S. Evidence-Based Medicine. November/December 2001. Vol.6. No.6. p.187.
Reviewed by Dr Bruce Arroll
Review: This article compares three Geriatric screening scales and a one question mental health inventory in elderly patients mean age 79 years. The gold standard was the DCR-10. The single question mental health inventory 1 was how much time over the past month have you felt downhearted or sad. All of the time = 6, most of the time = 5, a good bit of the time = 4, some of the time = 3 a little of the time = 2 and none of the time = 1. A score of three or greater had a sensitivity of 0.88 and a specificity of 0.71. (Original article reviewed: Int J Geriatr Psychiatr 2001 Mar; 16: 321-6)
Comment: There are problems with this study as the patients were inpatients and the one question was extracted from longer questionnaires. However although most commentators say that screening for depression in patients is not worth while it is often helpful to know that a patient is depressed so that the search for physical causes can slow down or stop.

22-389 Bipolar spectrum disorders: new perspectives.

Piver A, Yatham LN, Lam RW. Can Fam Physician Med Fam Can. May 2002.

Vol.48. p.896-904.
Reviewed by Dr Mike Lyons
Review: Search of Medline 1994-2001 formed the basis of the article. Outlines five classes of mood disorder. Useful mood disorder questionnaire for diagnosing hypomania included sensitivity 73% and specificity 90%. Emphasises pitfalls in diagnosis and potential problems with initiating treatment with an antidepressant. Brief mention of treatment options including mood stabilizers, antidepressants, anticonvulsants, atypical antipsychotics as well as cognitive and interpersonal therapy. Authors categorise the evidence for therapy.
Comment: Despite two of the authors sitting on the boards of a number of pharmaceutical companies (all three hold psychiatric hospital positions) this is an easily absorbed article on the current state of bipolar spectrum disorders.

22-390 Are SSRIs and TCAs equally effective for the treatment of panic disorder?

Brokaw DK. J Fam Pract. March 2002. Vol.51. No.3. p.279.
Reviewed by Dr Bruce Adlam
Review: Selective serotonin reuptake inhibitors (SSRIs) are commonly used as first-line treatment for panic disorder. This meta-analysis fails to support the hypothesis that SSRIs are more efficacious and better tolerated when compared with older antidepressants in the treatment of panic disorder. These results also contradict the popular belief that SSRIs are generally more tolerable than TCAs. TCAs can provide patients with an effective, well-tolerated, less-costly treatment for panic disorder. A similar conclusion was reached in a comparison between TCAs and SSRIs in the treatment of depression. (Original article reviewed: Am J Psychiatry 2001; 158: 1989-92)

22-391 Are paroxetine, fluoxetine, and sertraline equally effective for depression?

Straton JB, Cronholm P. J Fam Pract. March 2002. Vol.51. No.3. p.285.
Reviewed by Dr Bruce Adlam
Review: In this well designed study the answer is yes. Also nothing between them for the rates of adherence and of adverse effects. Using the lowest cost is an ethical and reasonable approach. (Original article reviewed: JAMA 2001; 286: 2947-55)

Respiratory System

22-392 Does amoxicillin improve outcomes in patients with purulent rhinorrhea? A pragmatic randomized double-blind controlled trial in family practice.

De Sutter AI, De Meyere MJ, Christiaens TC, et al. J Fam Pract. April 2002. Vol.51. No.4. p.317-23.
Reviewed by Dr Bruce Adlam
Review: Amoxicillin has a beneficial effect on purulent rhinorrhea caused by an acute infection of the nose or sinuses but not on general recovery. The practical implication is that all such patients, whatever the suspected diagnosis, can be safely treated with symptomatic therapy and instructed to return if symptoms worsen.

22-393 Is roxithromycin better than amoxicillin in the treatment of acute lower respiratory tract infections in primary care? A double-blind randomized controlled trial.

Hopstaken RM, Nelemans P, Stobberingh EE, et al. J Fam Pract. April 2002. Vol.51. No.4. p.329-36.
Reviewed by Dr Bruce Adlam
Review: Amoxicillin and roxithromycin are equally effective in the treatment of patients presenting with lower respiratory tract infections and needing antibiotic treatment. Most patients remain symptomatic after 10 days of treatment with either drug. The higher incidence of atypical pathogens (Mycoplasma pneumoniae, Legionella pneumophila, and Chlamydia pneumoniae) may guide the physician towards macrolide antibiotics over amoxicillin.

22-394 Do intranasal corticosteroids aid treatment of acute sinusitis in patients with a history of recurrent sinus symptoms?

Winn RJ. J Fam Pract. April 2002. Vol.51. No.4. p.386.
Reviewed by Dr Bruce Adlam
Review: Intranasal corticosteroids increase patient-reported clinical success when used in addition to antibiotics for the treatment of acute sinusitis in patients with a history of recurrent sinusitis (NNT = 6). Although the primary outcome of patient-reported clinical success was improved in the treatment group, the symptom scores also reported by the patients were not significantly different between groups. The current study did not adequately define 'recurrent', but a previous study found a similar benefit of intranasal steroids plus antibiotics for patients reporting at least two sinus infections requiring antibiotic treatment per year for at least the previous two years. (Original article reviewed: JAMA 2001; 286: 3097-105.)
Comment: There is no evidence that steroids provide additional benefit to the treatment of simple acute sinusitis. In addition, children who are given intranasal steroids for upper respiratory infections are more likely to develop ear infections.

22-395 When to suspect obstructive sleep apnea syndrome: Symptoms may be subtle, but treatment is straightforward.

Attarian HP, Sabri AN. Postgrad Med. March 2002. Vol.111. No.3. p.70-6.
Reviewed by Dr Chris Milne
Review: The partial or complete occlusion of the upper airway during sleep affects 2% of women and 4% of men. It manifests itself by snoring, excessive daytime sleepiness, nocturnal snoring and gasping, and witnessed apnoeic episodes. Reports by the bed partner are of great diagnostic importance. Formal evaluation in a sleep laboratory followed by weight loss, appropriate surgical procedures or CPAP (continuous positive airways pressure) is the management of choice.
Comment: Some patients seem reluctant to tolerate long term CPAP and

would rather have the clinical problem, but these cases deserve specialist review.

Rheumatic Diseases

22-396 Inflammatory rheumatologic disorders in the elderly: Unusual presentations, altered outlooks.

Belostocki KB, Paget SA. Postgrad Med. April 2002. Vol.111. No.4. p.72-83.
Reviewed by Dr Chris Milne

Review: Although polymyalgia rheumatica and giant cell arteritis are thought of as the classic rheumatic disorders of the elderly, other conditions may also occur in later life. Rheumatoid arthritis develops after age 60 in one third of cases. In elderly patients, the onset is more acute, tends to involve large proximal joints and is often rheumatoid factor negative. SLE may present in the elderly as cognitive dysfunction, failure to thrive, or fever of unknown origin.
Comment: Be on the lookout for these treatable conditions in your elderly patients.

Sexually Transmitted Diseases

22-397 What is the most effective treatment for external genital warts?

French L, Nashelsky J. J Fam Pract. April 2002. Vol.51. No.4. p.313.
Reviewed by Dr Bruce Adlam

Review: This evidence-based answer suggests podofilox (Condylox), imiquimod (Aldara), cryotherapy, and surgical options all seem reasonable alternatives that are superior to podophyllin. (Grade of recommendation: B, based on systematic review.) No studies of surgical options versus home use preparations have been reported. Trichloroacetic acid and 5-fluorouracil (5-FU) have not been sufficiently studied and data are lacking on recurrence rates with imiquimod, podofilox, and intralesional interferon.

Smoking

22-398 Does long-term bupropion (Zyban) use prevent smoking relapse after initial success at quitting smoking?

Barringer TA, Weaver EM. J Fam Pract. February 2002. Vol.51. No.2. p.172.
Reviewed by Dr Bruce Adlam

Review: Answer= Yes ...but. Highly motivated patients who stop smoking during the standard seven-week bupropion programme and stay on the drug are likely to be abstinent at one year (55%) . Once off bupropion the relapse rate is the same for those in the standard programme (40%). (Original article reviewed: Ann Intern Med 2001; 135: 423-33).

Sports and Sports Medicine

22-399 Surgical treatment for chronic Achilles tendinopathy: a prospective seven month follow up study.

Paavola M, Kannus P, Orava S, et al. Br J Sports Med. 1 June 2002. Vol.36. No.3. p.178-82.
Reviewed by Dr Chris Milne

Review: Short term results of surgical treatment of chronic achilles tendinopathy were satisfactory in this study. Of the 42 patients treated, 67% were able to resume full physical activity and 83% were asymptomatic or had only mild pain during strenuous exercise. The overall complication rate was 19%, with delayed wound healing being the most common problem.
Comment: Useful study, as there are very few prospective studies on this problem. All patients should undergo a progressive concentric then eccentric strengthening regime before surgery is performed.

22-400 Benefits and risks of using local anaesthetic for pain relief to allow early return to play in professional football.

Orchard JW. Br J Sports Med. 1 June 2002. Vol.36. No.3. p.209-13.
Reviewed by Dr Chris Milne

Review: This clinical case series is based on the author's experience with Australian Rules and Rugby League teams in Australia from 1996–2001. Local anaesthetic injections were used for 268 injuries to allow early return to play. There were 11 minor and six major complications, although none were catastrophic or career ending. About 10% of players taking the field did so with the assistance of local anaesthetic.
Comment: Important data about an intervention that is widely used in professional sport. Currently it is a banned practice in rugby union, but with data such as this being more widely promulgated, the issue may be reconsidered.

22-401 A prospective study of injuries to elite Australian rugby union players.

Bathgate A, Best JP, Craig G, et al. Br J Sports Med. 1 August 2002. Vol.36. No.4. p.265-9.
Reviewed by Dr Chris Milne

Review: Injuries in the Australian Wallabies team from 1994 to 2000 were recorded. These numbered 143 over 91 matches. An injury was defined as one that forced a player to either leave the field or miss a subsequent game. The injury rate was 47 per thousand player hours in 1994-95 period, and rose to 74 per thousand player hours in the 1996-2000 period after the game went professional. The tackle was responsible for 58.7% of injuries. Injuries were more likely to occur in the second half of the game.
Comment: Useful study. The data are comparable with those pertaining to New Zealand Super 12 team players.

22-402 Evaluating and managing muscle contusions and myositis ossificans.

Larson CM, Almekinders LC, Karas SG, et al. Physician and Sportsmedicine. February 2002. Vol.30. No.2. p.41-50.
Reviewed by Dr Rob Campbell

Review: Grading muscle contusions and assessing the risk of complications, such as myositis ossificans is the initial part of this paper. It then explores the evidence for the various treatment options.
Comment: If you are seeing contact sport patients read this and you have a 'state of the art' approach to muscle contusions.

22-403 Summary and agreement statement of the First International Conference of Concussion in Sport, Vienna 2001.

Concussion in Sport Group. Physician and Sportsmedicine. February 2002. Vol.30. No.2. p.57-63.
Reviewed by Dr Rob Campbell
Review: This conference produced an agreement statement regarding evaluation of concussion and subsequent management, rehabilitation and prevention. This area of sports medicine contains many difficult issues but you will get the best advice and guidelines from this paper.
Comment: This is the best article you can get on concussion worldwide.

Urology

22-404 PSA screening decisions influenced more by patient beliefs than by doctors.

Larkin M. Lancet. 22 June 2002. Vol.359. No.9324. p.2172.
Reviewed by Dr Tony Hanne
Review: A group at Yale used both a written survey and interviews with men who were counselled about the risk-benefits of PSA screening. 93% agreed that the information seemed unfavourable to PSA screening but 75% intended to do it anyway. Their previous beliefs remained largely unshaken.
Comment: This study demonstrates beautifully that giving a lecture to a patient is not the same thing as listening carefully to a patient's ideas and feelings before walking through to an agreed decision with him or her.

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" (New Zealand Medical Journal 1988, 101:200-204). Submit three clear copies, double spaced, wide margins and with numbered pages. Display on a separate title page the title of 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.

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

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

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

Subscriptions
The journal is provided free to all members of the RNZCGP. Rates for others are $90 per year within New Zealand, $80 plus $18 postage outside New Zealand. The Royal New Zealand College of General Practitioners, P O Box 10440, Wellington, New Zealand.

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

Editorial Board
Dr Bruce Arroll, Dr Andrew Divett, Professor Tony Dowell, Dr Pam Hyde, Professor Murray Tilyard, Dr Tony Townsend, Dr Jocelyn Tracey.

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

Management Committee
Lee Sheppard, Hugh Sutherland.

Designer
Robyn Atwood

Advertising enquiries:
Colin Gestro ph: 09-449 2500, fax: 09-449 2552, email: colingestro@affinityads.com

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

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

The Royal New Zealand College of General Practitioners