# Journal Review Service

*Continuing Medical Education in General Practice from the Goodfellow Unit*

**Journals Reviewed in this Issue**

Aust Fam Physician*
BMC Complement Altern Med
Br J Sports Med*
Drug Alcohol Rev*
Emerg Med Australas*
Evidence-Based Medicine*
Harm Reduct J*
Intern Med J*
J Appl Physiol*
J Fam Pract*
J Manipulative Physiol Ther*
JAMA*
Lancet*
N Engl J Med*
Obes Res*
Postgrad Med*
Reprod Biol Endocrinol*
Sci Am*
World J Gastroenterol*
*Journals indexed in Medline

## Acupuncture

### 25-346 Brain stem mechanisms underlying acupuncture modality-related modulation of cardiovascular responses in rats.

Zhou W, Tjen-A-Looi SC, Longhurst JC. J Appl Physiol. September 2005. Vol.99. No.3. p.851-60.

Reviewed by Dr Alex Chan

**Review:** The study involved locating neurons in the rostral ventral lateral medulla (rVLM) of anaesthetised rats and confirming their premotor sympathetic and cardiovascular sympathoexcitatory function by their response to stimulation of the intermediolateral column of the spinal cord between T2–T4 and to baroreceptor input respectively. Activities of these rVLM neurons during splanchnic nerve (visceral) stimulation were then recorded. Electroacupuncture (EA) at 2Hz and manual acupuncture (MA) at P-5 (Jianshi) and P-6 (Neiguan) were shown to inhibit evoked responses in the rVLM neurons from stimulation of the splanchnic nerve by 49% and 46% respectively. Inhibition lasted 20 minutes after cessation of EA or MA. The response was less with EA at higher frequencies.

**Comment:** Claims of an effect of acupuncture in various cardiovascular conditions such as hypertension, hypotension, arrhythmia and angina pectoris have been reported in the past. This study demonstrated a functional link between the acupuncture points P-5 and P-6 on the Pericardial Meridian and the premotor sympathetic cardiovascular neurons in the brainstem.

### 25-347 Long-term follow-up of a randomized clinical trial assessing the efficacy of medication, acupuncture, and spinal manipulation for chronic mechanical spinal pain syndromes.

Muller R, Giles LG. J Manipulative Physiol Ther. January 2005. Vol.28. No.1. p.3-11.

Reviewed by Dr Alex Chan

**Review:** This follow-up study explored the long-term effects in chronic spinal pain patients who were randomised to treatment exclusively with only manipulation, acupuncture or medicine. Sixty-two out of 69 patients returned the follow-up questionnaires. Intention-to-treat analysis (n=62) showed that manipulation and acupuncture were equally effective. However, compliers-only analysis (n=40) showed significant improvement occurred in five out of seven measures in patients treated

with manipulation alone but only in one out of seven measures with either acupuncture or medicine. Measures used in the analysis were pain frequency (neck, back), VAS pain scale (neck, back), Oswestry Back Pain Index, Neck Disability Index and SF-36. Manipulation was superior in all scores except Oswestry Back Pain Index, and VAS back pain scale. Acupuncture resulted in significant improvement in Oswestry Back Pain Index while medicine improved SF-36 in the compliers-only analysis.

**Comment:** The investigators performed additional analyses to assess potential confounding effects of variables such as age, sex, BMI, pain duration and involvement in litigation in the compliers-only analysis. These were found to be non-significant. However, there was no discussion on the possible contributing effects of social/economic or occupation factors among the groups: manipulation vs acupuncture vs medicine, e.g. pensioner/unemployed (30.4% vs 5% vs 21.1%), tradesman (17.4% vs 25% vs 26.3%), and (para)professional (13% vs 25% vs 15.8%). Further larger scale study taking these factors into consideration would help to clarify the situation.

### 25–348 Efficacy of acupuncture for cocaine dependence: a systematic review and meta-analysis.

Mills EJ, Wu P, Gagnier J, et al. Harm Reduct J. 17 March 2005. Vol.2. No.1. p.4 (6 pages)

Reviewed by Dr Alex Chan

**Review:** A systematic review and meta-analysis of RCTs assessing the effect of acupuncture on cocaine dependence. Nine trials out of 83 studies were selected for final analysis. Studies only included if their patients had cocaine dependence alone and were randomly allocated to either acupuncture, sham or other control. All were conducted in the USA. All nine trials employed ear acupuncture. Controls included sham acupuncture, relaxation, anti-craving medication and brain modification or psychosocial treatment. This systematic review and meta-analysis yielded inconclusive data on the effect of acupuncture on cocaine dependence.

**Comment:** There was large dropout of enrolled participants in most of the studies, averaged 50%, and also some studies included patients using methadone in addition to cocaine while others did not. These made it difficult to interpret the final results of the pooled studies.

### 25–349 Effect of electro-acupuncture on ovarian expression of alpha (1)- and beta (2)- adrenoceptors, and p75 neurotrophin receptors in rats with steroid-induced polycystic ovaries.

Manni L, Lundeberg T, Holmang A, et al. Reprod Biol Endocrinol. 7 June 2005. Vol.3. No.1. p.21 (13 pages)

Reviewed by Dr Alex Chan

**Review:** 2Hz electroacupuncture treatment was applied bilaterally in somatic segments corresponding to the innervation of the ovaries in rats with steroid-induced polycystic ovaries and in controls. Ovarian expression and distribution of alpha 1a-, alpha 1b, alpha 1d, beta 2- adrenoreceptors and the neurotrophin receptor p75NTR were assessed. It was found that EA prevented most of the steroid-induced changes in the rats' ovarian adrenoreceptors, and counteract the steroid-induced up regulation of p75NTR.

**Comment:** The authors had previously found repeated low-frequency EA treatments induced regular ovulations in more than one-third of women with PCOS and normalised endocrine and neuroendocrine parameters. This study was an attempt to elucidate the underlying mechanism for the response to EA in polycystic ovaries. A well designed and well written-up research article.

### 25–350 Electrical impedance along connective tissue planes associated with acupuncture meridians.

Ahn AC, Wu J, Badger GJ, et al. BMC Complement Altern Med. 9 May 2005. Vol.5. No.1. p.10 (9 pages)

Reviewed by Dr Alex Chan

**Review:** An interesting study in which the authors tried to examine the electrical impedance of connective tissue planes associated with meridians. Segments of the Pericardium meridian in the forearm and the Spleen meridian in the leg were used in the study. Needles were inserted to a depth of 10mm through a holder which was placed on the meridians with control needles along a parallel line 0.8cm medial to the meridians. Tissue impedance was found to be lower along the Pericardium meridian but not along the Spleen meridian.

**Comment:** Results of this study could not be expected to be reliable be-

cause the depth of needle insertion was mechanically fixed at 10mm and not determined by ultrasound in each instance. Also, the measurements represented electrical impedance between two needles of all the layers of tissues from the skin surface to the tip of the needles. This would be expected to be different from the electrical impedance of the connective tissue planes which the authors wanted to measure. To do so would require the shafts of the needles to be insulated but with the tip of the needles exposed. However, the study will help to inform future researchers of methodological issues which require special attention.

**25–351 Acupuncture for irritable bowel syndrome: A blinded placebo-controlled trial.**

Forbes A, Jackson S, Walter C, et al. World J Gastroenterol. 14 July 2005. Vol.11. No.26. p.4040-4.

Reviewed by Dr Alex Chan

**Review:** A double blind, sham-controlled trial of TCM acupuncture therapy for 12 weeks in 59 irritable bowel syndrome patients who had failed to respond to standard therapies including increased dietary fibre, reduction of lactose containing foods, antispasmodics, simple laxative and opioids. A diagnosing acupuncturist assessed the patients and prescribed the acupuncture points while a treating acupuncturist needled the patient following randomisation either actively as prescribed or by using sham acupuncture points. Patients were divided into two groups with the roles of the two acupuncturists reversed in the groups. It was concluded that formal acupuncture (which had 40.7% responders) failed to elicit significant advantage over sham acupuncture (31.2%) and therefore not better than placebo.

**Comment:** As usual, sham acupuncture was assumed to be inert because the needles were placed in areas deemed to be away from the acupuncture meridians. This may not be necessarily true.

## Alcohol and Substance Abuse

**25–352 Correlates of Ecstasy use in middle age and beyond.**

Williams P. Drug Alcohol Rev. January 2005. Vol.24. No.1. p.33-8.

Reviewed by Dr Helen Moriarty

**Review:** Drug use, especially party drug use, is popularly believed to be a youth phenomenon. An Australian National Drug Household Survey in 1998 blew some of these myths. Middle-aged women (45 years and over) knew friends who had used ecstasy or had personally tried it themselves. Correlates of ecstasy use were: approval of use by adults, legislation support, and histories of amphetamine, cocaine or cannabis use in the past.

**Comment:** Sexism should not colour drug user judgement or screening for drug use. The 'flower power' hippie population is now aged 55 years plus.

**25–353 Is cannabis a gateway drug? Testing hypotheses about the relationship between cannabis use and the use of other illicit drugs.**

Hall WD, Lynskey M. Drug Alcohol Rev. January 2005. Vol.24. No.1. p.39-48.

Reviewed by Dr Helen Moriarty

**Review:** A comprehensive review, taking particular note of twin studies to consider three hypotheses: shared drug illicit market for cannabis and other drugs; affiliation of cannabis users with other drug users; socialisation into the illicit drug culture and attitude changes. The conclusion is that all three are contributors to gateway drug use following cannabis. The relative contribution of each is unclear.

**Comment:** The moral of this story is not to consider a little bit of cannabis use as benign.

**25–354 Recreational drug use within the employees of the mariculture and seafood industry in South Australia.**

Evans AR, Tait R, Harvey P, et al. Drug Alcohol Rev. January 2005. Vol.24. No.1. p.67-8.

Reviewed by Dr Helen Moriarty

**Review:** A self-report questionnaire was used within workers in the seafood industry. A high rate of cannabis use was found (44.2% use in the preceding year). Permanent offshore workers were also higher amphetamine users. Heavy drinking and smoking was also a feature of this population. The OSH implications in such a dangerous work setting were clear. Reasons for such drug use are harder to address.

**Comment:** NZ has similar industries associated with similar drug use patterns. GPs should be alert to this in patients from fishing and forestry jobs especially.

## Alcohol Drinking

**25–355 'Think before you buy under-18s drink': evaluation of a community alcohol intervention.**

Kypri K, Dean J, Kirby S, et al. Drug Alcohol Rev. January 2005. Vol.24. No.1. p.13-20.

Reviewed by Dr Helen Moriarty

**Review:** A NZ initiative to discourage inappropriate supply of alcohol to under-18s by adults was run in Ashburtion, Waitaki and Clutha. Outcome measures were: changes in parent supply for unsupervised drinking – by teenager and parent reports. There was no significant change in supply for unsupervised drinking, but a downward trend. Researchers suspect that teenage binge-drinking is also supplied by older peers and underage purchasers.

**Comment:** There are wide societal implications of underage drinking, a phenomenon that we still do not understand well. This is also high on the political agenda at present.

## Asthma

**25–356 High-dose zafirlukast in emergency department provides small benefit in acute asthma.**

J Fam Pract. April 2005. Vol.54. No.4. p.304, 306.

Reviewed by Dr Bruce Adlam

**Review:** A high dose of zafirlukast slightly reduces the number of patients who have an extended stay in the emergency department (number needed to treat [NNT]=20). Continuing zafirlukast at a dose of 20mg twice a day slightly improves outpatient outcomes as well (NNT=20 to prevent relapse). (Original article reviewed: Chest 2004; 126:1480-1489)
**Comment:** Read 'reduces' as 'may reduce' and 'slightly' as 'minimally'. All patients were also given steroids and albuterol.

## Cardiovascular System

### 25–357 Vitamin E not helpful, perhaps harmful.

J Fam Pract. March 2005. Vol.54. No.3. p.199-200.
Reviewed by Dr Bruce Adlam
**Review:** This meta-analysis of RCTs suggests vitamin E supplementation does not decrease all-cause mortality in patients with or without pre-existing heart disease. At higher doses it can actually be harmful, although the deleterious effect is small (number needed to harm =250) (Level of evidence =1b).
**Comment:** There was also no difference by age or gender. (Original article reviewed: Ann Intern Med 2005; 142: 37-46).

### 25–358 Use CCBs as last resort in treatment of hypertension.

J Fam Pract. March 2005. Vol.54. No.3. p.203-4.
Reviewed by Dr Bruce Adlam
**Review:** In this prospective cohort study of 93 000 women over an average of 5.9 years with hypertension and no history of cardiovascular disease (CVD), a regimen of a diuretic plus either a beta-blocker or angiotensin-converting enzyme (ACE) inhibitor reduces the risk of CVD mortality compared with a diuretic plus calcium channel blocker. The evidence continues to mount that calcium channel blockers should be the agent of last resort in the treatment of most patients with hypertension. (Level of evidence 2b) (Original article reviewed: JAMA 2004; 292: 2849-59).

### 25–359 Guidelines for the treatment of chronic stable angina.

J Fam Pract. March 2005. Vol.54. No.3. p.206.
Reviewed by Dr Bruce Adlam
**Review:** The bottom line from these guidelines is, in patients who have either chronic stable angina without a history of myocardial infarction or a revascularization procedure in the past six months, as well as in asymptomatic patients with demonstrated coronary artery disease, the following should be routine: aspirin; a beta-blocker; an angiotensin-converting enzyme inhibitor; and a statin, if the cholesterol is above normal. (LOE=1a) (Original article reviewed: Ann Intern Med 2004; 141: 562-7).

### 25–360 What is the best regimen for newly diagnosed hypertension?

Saseen JJ, Turner C, Russell RG. J Fam Pract. March 2005. Vol.54. No.3. p.281-2.
Reviewed by Dr Bruce Adlam
**Review:** Low-dose thiazide diuretics (e.g. hydrochlorothiazide 12.5 to 25 mg/d) are the best first-line pharmacotherapy for treating uncomplicated hypertension (strength of recommendation A). Alternate first-line agents include angiotensin-converting enzyme (ACE) inhibitors, beta-blockers, and calcium channel blockers.
**Comment:** Commentary following article makes a good point. Cost effectiveness supports thiazides as first-line pharmacotherapy. The debate of which agent to use first may be moot considering most hypertensive patients require two or more drugs to achieve a systolic blood pressure goal of <140 mm Hg.

### 25–361 B-type natriuretic peptides: applications for heart failure management in 2005.

Troughton RW, Richards M. Intern Med J. July 2005. Vol.35. No.7. p.377-9.
Reviewed by Dr Helen Moriarty
**Review:** A useful (two-page) summary of the clinical application of BNP. It differentiates CHF from other causes of acute dyspnoea. High negative predictive value helps to rule out heart failure. There is debate about the cut-off levels needed to rule the diagnosis in. Until this is solved, there will be limitations in using BNP for screening, except where there is a high pre-test probability of CHF.
**Comment:** The Christchurch group have pioneered BNP research for decades. Another use of BNP is as a prognostic predictor of subsequent mortality or heart failure – complementary to echo ejection fraction and other markers. The role in guiding CHF management is therefore still not yet decided.

## Communicable Diseases, Infections and Parasites

### 25–362 Review: antibiotics active against atypical pathogens do not improve community acquired pneumonia more than beta lactam antibiotics.

Marrie TJ. Evidence-Based Medicine. August 2005. Vol.10. No.4. p.115.
Reviewed by Dr Bruce Arroll
**Review:** This was a systematic review of randomised, blinded (investigators, patients, and outcome assessors), controlled trials (RCTs) that com-

pared AAAAPs (fluoroquinolones, macrolides, and ketolides) with ß lactam antibiotics (penicillins and cephalosporins) in patients with radiographically confirmed CAP. The trials evaluated nine different fluoroquinolones, two macrolides, and one ketolide. Time of outcome assessment ranged from the end of treatment to 38–42 days after commencement of antibiotics. No RCT showed a difference between groups in failure to achieve clinical cure or improvement and no significant heterogeneity existed between studies. Pooled analysis showed no overall difference between groups for failure to achieve cure or improvement and no difference when analyses were done separately on type of AAAAP. No treatment effect was seen in patients with Mycoplasma pneumoniae (13 RCTs) (relative risk [RR] 0.60, 95% CI 0.31 to 1.17) or Chlamydia pneumoniae (7 RCTs) (RR 2.32, CI 0.67 to 8.03), but a reduction in failure to achieve cure or improvement with AAAAPs was seen in patients with Legionella species (10 RCTs) (RR 0.40, CI 0.19 to 0.85). AAAAPs and ß lactam antibiotics did not differ for all cause mortality (RR 1.20, CI 0.84 to 1.71). (Original paper reviewed: BMJ 2005; 330: 456)
**Comment:** These findings suggest that antibiotics such as amoxil and augmentin are effective in mild to moderate community acquired pneumonia. This was not the case for legionella where the macrolides found a benefit.

## Dermatology

### 25–363 Eczema: Practical management issues.

Ross T, Ross G, Varigos G. Aust Fam Physician. May 2005. Vol.34. No.5. p.319-24.
Reviewed by Dr Rachel Monk
**Review:** Fantastic article reminding GPs of the appropriate management of eczema.
**Comment:** Eczema can sometimes be challenging to manage and I think most GPs would find this a good article to read.

### 25–364 Occupational dermatoses.

Nixon R, Frowen K, Moyle M. Aust Fam Physician. May 2005. Vol.34. No.5. p.327-33.
Reviewed by Dr Rachel Monk
**Review:** The most common occupational dermatosis is contact dermatitis, which is more common in males and the vast majority of cases affect the hand. Occupational dermatoses are by no means uncommon and this article will help the GP not only with recognition but also aid in early and appropriate treatment.
**Comment:** I found this article really helpful. I hope you will too.

### 25–365 Cutaneous manifestations of systemic disease.

Cahill J, Sinclair R. Aust Fam Physician. May 2005. Vol.34. No.5. p.335-40.
Reviewed by Dr Rachel Monk
**Review:** Case based article illustrating five skin rashes and the possible associated underlying disorder.
**Comment:** Helpful examination and investigation suggestions in each case.

### 25–366 Management of infantile eczema.

King E. Aust Fam Physician. May 2005. Vol.34. No.5. p.341.
Reviewed by Dr Rachel Monk
**Review:** Great little one page patient handout on how to manage eczema including information on how to do wet wraps.

### 25–367 Procedures in primary care dermatology.

Chuh A, Wong WC, Wong SY. Aust Fam Physician. May 2005. Vol.34. No.5. p.347-51.
Reviewed by Dr Rachel Monk
**Review:** Nice article on a number of procedures that can be performed in general practice. Short discussion on each and its potential uses.

## Emergency Medicine

### 25–368 Use and toxicity of complementary and alternative medicines among emergency department patients.

Taylor DM, Walsham N, Taylor SE, et al. Emerg Med Australas. October /December 2004. Vol.16. No.5/6. p.400-6.
Reviewed by Dr Jocelyn Tracey
**Review:** This study provides data on the prevalence and type of complementary and alternative medicines (CAM) used by patients presenting at ED. On the day of presentation 12.4% had used CAM, and 50.2% within the previous week. CAM use was highest in young, well-educated women. Data is provided on the most common types of CAM used, and on the most common side effects (side effect rate of 4.5%). CAMs may alter the presentation of illness, cause the presenting symptoms, and interact with the medications we prescribe.
**Comment:** This article provides helpful information for GPs on the most commonly used CAM preparations and their side effects. It is a useful reminder to check all the preparations patients are taking. (Commentary on p. 378-81)

### 25–369 Epistaxis.

Middleton PM. Emerg Med Australas. October/December 2004. Vol.16. No.5/6. p.428-40.
Reviewed by Dr Jocelyn Tracey
**Review:** This is a review article covering the pathology, diagnosis and management of epistaxis. Despite multiple known causes including environmental, local, systemic and medications, in 85% of cases no cause is found. There is a reminder to use continuous digital compression for 10–15 minutes as this exceeds the bleeding time. Other practical hints include the use of Drixine soaked cotton wall balls, details regarding the application of silver nitrate, the use of antiseptic nasal cream to prevent recurrent epistaxis in children and anterior packing with Merocel nasal tampons.
**Comment:** A thorough and helpful review.

### 25–370 Review of branch aortic injuries in blunt chest trauma.

Holdgate A, Dunlop S. Emerg Med Australas. February 2005. Vol.17. No.1. p.49-56.
Reviewed by Dr Jocelyn Tracey
**Review:** These injuries are more common in rapid deceleration injuries and falls. Physical findings are often absent or non-specific and 50% of patients have no external signs of chest trauma. Fortunately CXR has a sensitivity of over 85%.
**Comment:** A useful article for those involved in PRIME or working in A&M clinics.

**25-371 Tramadol: does it have a role in emergency medicine?**
Close BR. Emerg Med Australas. February 2005. Vol.17. No.1. p.73-83.
Reviewed by Dr Jocelyn Tracey
**Review:** This article reviews the pharmokinetics, clinical use, adverse effects, precautions and interactions of tramadol.
**Comment:** A useful article for those unsure when to recommend this unsubsidised medication.

**25-372 Patient delay and use of ambulance by patients with chest pain.**
Ingarfield SL, Jacobs IG, Jelinek GA, et al. Emerg Med Australas. June 2005. Vol.17. No.3. p.218-23.
Reviewed by Dr Jocelyn Tracey
**Review:** 151 patients with an ED diagnosis of acute myocardial infarction were interviewed. Three independent predictors of delay in reaching ED were seeing a GP before proceeding to hospital, having a previous heart related problem and symptoms occurring at night.
**Comment:** There is food for thought here about how we manage patients with chest pain in general practice, particularly in regards to advice given to patients with chest pain ringing the surgery, and in regards to ensuring that patients with previous heart disease have an appropriate chest pain action plan.

**25-373 Ovarian torsion: 10-year perspective.**
White M, Stella J. Emerg Med Australas. June 2005. Vol.17. No.3. p.231-7.
Reviewed by Dr Jocelyn Tracey
**Review:** This article reviews 52 cases of ovarian torsion gathered over 10 years. Given the rarity of the diagnosis and the lack of specificity of the clinical presenting signs and symptoms (sudden onset constant pain with nausea and vomiting, abdominal mass) it is not surprising that ovarian torsion was considered in the initial differential diagnosis in only 19.2% of patients. Thirty per cent had recognised risk factors.
**Comment:** If this diagnosis has dropped off your radar screen, then this article provides a useful review.

**25-374 Traumatic brain injury: The need for support and follow up.**
Olver J. Aust Fam Physician. April 2005. Vol.34. No.4. p.269-71.
Reviewed by Dr Rachel Monk
**Review:** The impact of minor traumatic brain injury is often underestimated. This article has two interesting case studies, which illustrate this. Good tips re diagnosing too – neuropsychological testing is the gold standard.
**Comment:** Have a read. I think you'll find this interesting.

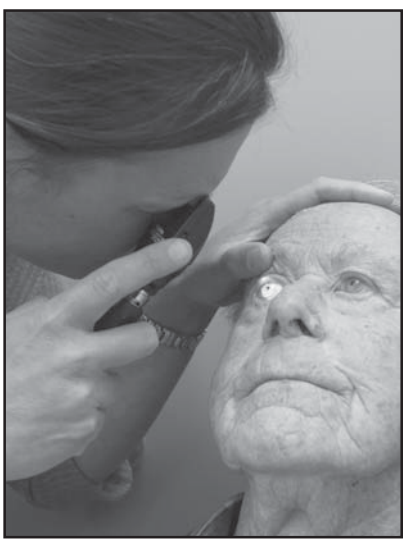
## Evidence-Based Medicine

**25-375 Using the likelihood ratio.**
Okada T, Rao G. J Fam Pract. February 2005. Vol.54. No.2. p.127-8.
Reviewed by Dr Bruce Adlam
**Review:** Another useful item in this series. They're concise, clear and sensible.

## Eye Diseases

**25-376 Open-angle glaucoma: Tips for earlier detection and treatment selection.**
Aref AA, Schmitt BP. J Fam Pract. February 2005. Vol.54. No.2. p.117-25.
Reviewed by Dr Bruce Adlam
**Review:** Excellent article, aimed at the primary care physician, that looks at screening, who to screen, determining the optic nerve status, what to look for, when to refer, what treatments are currently used, new surgical techniques and follow-up at the primary care level.
**Comment:** Excellent base article for PHAs considering glaucoma detection programmes. Has extensive bibliography.

**25-377 Chloramphenicol treatment for acute infective conjunctivitis in children in primary care: a randomised double-blind placebo-controlled trial.**
Rose PW, Harnden A, Brueggemann AB, et al. Lancet. 2-8 July 2005. Vol.366. No.9479. p.37-43.
Reviewed by Dr Tony Hanne
**Review:** 326 children between six months and 12 years were randomised to treatment or placebo after swabbing for bacterial and viral infection. Parents kept diaries. They were reassessed at seven days for clinical cure and followed to six weeks for possible recurrence. The marginally better rate of cure with chloramphenicol was not significant. Relapse rates were no different. Symptoms were slightly better relieved with active treatment possibly due to the lubricant effect of the vehicle. The presence of bacteria made no difference to the outcome.



**Comment:** There are still unanswered questions like whether the rate of transmission is reduced by treatment. New born were not included and so transmission during vagina delivery remains a concern. C.trachomatis in developing countries would still be an important reason for treatment. This study may explain why traditional treatments such as breast milk are popular; they are as good as placebo! (see also 25-378)

**25-378 Conjunctivitis in children.**

Normann EK. Lancet. 2-8 July 2005. Vol.366. No.9479. p.6-7.

Reviewed by Dr Tony Hanne

**Review:** See 25-377.

## Family Practice

**25-379 Part I. General practitioner-specialist relationship.**

Piterman L, Koritsas S. Intern Med J. July 2005. Vol.35. No.7. p.430-4.

Reviewed by Dr Helen Moriarty

**Review:** This first paper explores how the division between generalist and specialist became drawn, and looks at reasons why paradigms and role dynamics lead sometimes to friction and professional separatism. It also discusses those 'specialities' that arose from GP work, and which now disenfranchise special interest GPs (women's health, sports medicine, palliative care, etc.).

**Comment:** A short (four page) and thoughtful paper written by authors from the Dept. of General Practice in Monash. Roll on Part II!

## Gastroenterology

**25-380 Ten years after bariatric surgery: weight loss sustained, diabetes and hypertension reversed.**

J Fam Pract. March 2005. Vol.54. No.3. p.204, 6.

Reviewed by Dr Bruce Adlam

**Review:** In this non-randomised controlled trial, bariatric surgery successfully helped patients lose weight and reverse diabetes, hypertension, and some hyperlipidemias. It's unknown whether it affects all-cause mortality. (Level of evidence 2c) (Original article reviewed: N Engl J Med 2004; 351: 2683-93).

**25-381 Gastrointestinal injury from NSAID therapy: How to reduce the risk of complications.**

Lanas A. Postgrad Med. June 2005. Vol.117. No.6. p.23-31.

Reviewed by Dr Chris Milne

**Review:** NSAID use increases the risk of upper GI bleeding by a factor of 3.8. After a year of NSAID use, about 1% of patients will have experienced an upper GI complication – most are bleeding, only a few are ulcer perforation or obstruction. Common strategies include: reducing NSAID use, using lower doses, co-prescription of a gastro protectant (usually a proton pump inhibitor) or use of a COX-2 inhibitor.

**Comment:** Although this article doesn't mention it, I would say – for mechanical musculoskeletal pain, look for a mechanical solution where this is practicable.

**25-382 Aspirin plus PPI safer than clopidogrel if there is history of GI bleeding.**

J Fam Pract. April 2005. Vol.54. No.4. p.308-9.

Reviewed by Dr Bruce Adlam

**Review:** In this double blind RCT for patients with a history of bleeding peptic ulcer, the combination of aspirin and a proton pump inhibitor (PPI) twice a day was safer than clopidogrel in terms of bleeding side effects. Although esomeprazole was used in this study, generic omeprazole 20mg given twice a day provides nearly the same degree of acid suppression at a much lower cost. This study calls into question the overall safety of clopidogrel, which has been claimed to not significantly increase the risk of bleeding (Level of Evidence =1b). (Original article reviewed: N Engl J Med 2005; 352:238-244) (See also 25-383).

**25-383 Aspirin plus esomeprazole reduced recurrent ulcer bleeding more than clopidogrel in high risk patients.**

Peterson WL. Evidence-Based Medicine. August 2005. Vol.10. No.4. p.112.

Reviewed by Dr Bruce Arroll

**Review:** This was a randomised controlled trial of clopidogrel, 75mg, plus placebo (n=161) or aspirin, 80mg, plus esomeprazole, 20mg (n=159) twice daily for 12 months in patients with recurrent bleeding due to aspirin use. The PPI + aspirin had an incidence of recurrent bleeding of 0.7% while the clopidogrel had an 8.6% chance of bleeding. The NNH for this is 13. (Original paper reviewed: N Engl J Med 2005; 352: 238- 44).

**Comment:** Although clopidogrel had been believed to be non-ulcerogenic, it was associated with a substantially higher incidence of recurrent ulcer bleeding than was low dose aspirin plus a PPI (esomeprazole). Because the incidence of adverse events prevented by antiplatelet therapy was similar in the two groups, the recommendation to switch patients with a previous aspirin associated bleeding ulcer to clopidogrel alone is not justified. In patients who truly cannot take aspirin, clopidogrel could be used with a concomitant PPI, although this has not yet been proven to be safe. In NZ clopidogrel is not

funded so the aspirin and PPI would be the option. (see also 25-382).

**25–384 Irritable bowel syndrome.**
Bolin TD. Aust Fam Physician. April 2005. Vol.34. No.4. p.221-4.
Reviewed by Dr Rachel Monk
**Review:** Nice little summary on irritable bowel syndrome and its management. Discussion on potential causes too.
**Comment:** Includes the Rome II diagnostic criteria, which is useful in diagnosis.

**25–385 Acute gastroenteritis in children.**
Webb A, Starr M. Aust Fam Physician. April 2005. Vol.34. No.4. p.227-31.
Reviewed by Dr Rachel Monk
**Review:** Great and very helpful article. Very useful section regarding assessing dehydration. Also a guide to management, especially in respect to using oral rehydration solutions.
**Comment:** This is an extremely common problem in general practice and I think every GP will find this article helpful.

**25–386 Inflammatory bowel disease.**
Gibson PR, Iser J. Aust Fam Physician. April 2005. Vol.34. No.4. p.233-7.
Reviewed by Dr Rachel Monk
**Review:** Key message for GPs in this article is to suspect inflammatory bowel disease (IBD) if you wish to avoid a delay in diagnosis. Very helpful information regarding management.
**Comment:** Well worth a read.

**25–387 Coeliac disease.**
Anderson RP. Aust Fam Physician. April 2005. Vol.34. No.4. p.239-42.
Reviewed by Dr Rachel Monk
**Review:** 'Coeliac disease probably affects 1:100 Australians but is underdiagnosed.' Once again the diagnosis must be considered if it is going to be investigated for and ultimately made. Useful discussion on the tests used to diagnose coeliac disease.

## Genetics

**25–388 The alternative genome.**
Ast G. Sci Am. April 2005. Vol.292. No.4. p.40-7.
Reviewed by Dr Ron Vautier
**Review:** By the splicing of its parts in various ways a single gene can give rise to a variety of different proteins. Thus a more complex organism e.g. humans, may well have fewer genes than a simpler one, e.g. corn. In fact this mechanism is common, and we begin to understand what the so-called 'junk DNA' is actually all about.
**Comment:** This article provides a clear explanation of the current understanding, and discusses therapeutic possibilities that arise.

## Geriatrics

**25–389 A functional task exercise programme was better than a resistance exercise programme in elderly women.**
Luxenberg JS. Evidence-Based Medicine. August 2005. Vol.10. No.4. p.119.
Reviewed by Dr Bruce Arroll
**Review:** This was a randomised controlled trial of FTP (core exercises done for >2 of four domains [moving with a vertical or horizontal component, carrying an object, and changing between lying-sitting-standing position] in three sessions of five to 10 repetitions) (n = 33), (ii) REP (exercises to strengthen the muscle groups that are important for daily task performance in three sets of 10 repetitions) (n = 34), or (iii) control (normal pattern of activity) (n = 31). Exercises were done three times/week (1h sessions). They found participants in the FTP had a greater increase in ADAP total score compared with those who received REP or the control intervention ($p<0.001$). FTP and REP groups did not differ for TUG, HGS, or LEP. The REP and control groups did not differ for ADAP total score ($p=0.06$), TUG ($p=1.00$), or HGS ($p=1.00$). REP improved IKES and IEFS more than FTP. (Original paper reviewed: J Am Geriatr Soc 2005; 53: 2-10)
**Comment:** We should consider recommending functionally relevant exercise to our elderly patients.

## Gynaecology

**25–390 Management of benign breast conditions: Part 2 – breast lumps and lesions.**
Brennan M, Houssami N, French J. Aust Fam Physician. April 2005. Vol.34. No.5. p.253-5.
Reviewed by Dr Rachel Monk
**Review:** Benign breast lumps are common and often worrying to the patient. Discussion in this article around the clinical and imaging findings of some benign breast lumps (localised nodularity, breast cysts, fibroadenoma, fibrocystic disease).
**Comment:** Patient education sheet on breast cysts available on Page 257 (attached). (See 25- 296 in a previous issue of the JRS and 25-391 in this issue.)

**25–391 Management of benign breast conditions: Part 3 – other breast problems.**
Brennan M, Houssami N, French J. Aust Fam Physician. May 2005. Vol.34. No.5. p.353-7.
Reviewed by Dr Rachel Monk
**Review:** Brief discussion on nipple discharge, inflammatory breast conditions and gynaecomastia. Useful patient handout on nipple discharge on page 357 (attached).
**Comment:** This whole series has been great so far – have a read. (See 25-296 in a previous issue of the JRS and 25-390 in this issue.)

## Law and Medicine

**25–392 Giving evidence.**
Williams A. Aust Fam Physician. April 2005. Vol.34. No.4. p.250-2.
Reviewed by Dr Rachel Monk
**Review:** An article well worth reading if you are required to give evidence in court. Helpful hints on how to do the best you can.

## Musculoskeletal System

### 25–393 Review: early mobilisation is better than cast immobilisation for injured limbs.

Kreder HJ. Evidence-Based Medicine. August 2005. Vol.10. No.4. p.118.
Reviewed by Dr Bruce Arroll

**Review:** This was a systematic review of 49 RCTs which met the selection criteria. Sixteen trials were considered to be of high quality (score 11). Follow up ranged from 1–60 months. Ten RCTs were of lower limb fractures, 21 of lower limb injuries without fracture, 16 of upper limb fractures, and two of upper limb injuries without fracture. Rest comprised cast immobilisation (duration range 10 d to 8 wks). Mobilisation strategies included some form of limb support (e.g. brace, splint, or short period of immobilisation) or minimal or no support (e.g. orthoses, crutches, bandages, or tape) and could include active exercise. They found that in no study did cast immobilisation improve pain and swelling. In nine RCTs, patients were more satisfied with early mobilisation than a cast. Early mobilisation was associated with better global function composite scores after six months (six RCTs) and after 12 months (one RCT). Patients returned to work sooner after early mobilisation in 13 RCTs, particularly for lower limb non-fracture injuries (eight RCTs). In five RCTs, early mobilisation prompted an earlier return to sport. Early mobilisation improved range of motion in patients with upper and lower limb fracture (14 RCTs). Early mobilisation reduced deformity in Colles' fractures (two RCTs), meta-carpal fractures (one RCT), and radial fractures (one RCT). Ten RCTs showed no change in deformity, no loss of fracture reduction, and no other complications after early mobilisation. (Original paper reviewed: J Fam Pract 2004; 53: 706-12)

**Comment:** The commentator said 'Given the harmful effects of joint immobilisation, it is important that emergency medicine and family practice physicians educate patients about the positive results of early mobilisation after limb injury and abandon the practice of casting "for comfort" in adults, although some patients may still value a walking cast more than crutches. The results of this systematic review support a flexible approach to management, and physicians should consider which method best addresses factors such as patient preferences, an efficient use of resources (e.g. time in the emergency department and number of follow up visits), and indirect costs to the patient such as loss of wages. Further research would be helpful to determine if immediate weightbearing and mobilisation are safe for all types of leg injuries.

### 25–394 Bone mineral density and the risk of incident nonspinal fractures in black and white women.

Cauley JA, Lui L-Y, Ensrud KE, et al. JAMA. 4 May 2005. Vol.293. No.17. p.2102-8.
Reviewed by Dr Raina Elley

**Review:** This prospective cohort study of 7334 White women and 636 Black women over 65 years in the US, found that there was lower risk of fracture at every bone mineral density for Black women compared with White women (e.g. with one SD decrease in femoral head density relative risk of 1.37 95% CI 1.08–1.74; and RR 1.49 95%CI 1.40–1.58, respectively). When other risk factors were controlled for, it was found that most of the RR for Black women could be explained by other risk factors rather than low bone density, while bone density was still an important predictor of fracture amongst White women.

**Comment:** This paper has suggested 'race-specific normative databases' for the definition of osteoporosis based on bone density. There is little data on the risk of fracture and its association with lowered BMD of non-European ethnic groups in New Zealand but there is a suspicion that the risk and association are different. (see also 25-395)

### 25–395 Bone density and the risk of fractures: Should treatment thresholds vary by race?

Acheson LS. JAMA. 4 May 2005. Vol.293. No.17. p.2151-4.
Reviewed by Dr Raina Elley

**Review:** See 25-394.

### 25–396 Screening for osteoporosis.

Raisz LG. N Engl J Med. 14 July 2005. Vol.353. No.2. p.164-71.
Reviewed by Dr Raina Elley

**Review:** Interesting discussion about whether or not to screen for osteoporosis.

**Comment:** Disappointing that this paper does not address the conflicting evidence recently come to light about the value of Calcium and Vitamin D in community-dwelling older adults in preventing fractures. (Two recent trials showed no reduction in fractures – although there is evidence for protection against fracture for those in residential care).

## Neurology

### 25–397 His brain, her brain.

Cahill L. Sci Am. May 2005. Vol.292. No.5. p.22-9.
Reviewed by Dr Ron Vautier

**Review:** Neuroscientists are uncovering consistent anatomical, chemical and functional differences between the brains of men and women in regions involved in language, memory, emotion, vision, hearing and navigation. It seems that sex-specific therapies for psychological disorders might be optimal.
**Comment:** Is anyone surprised?

### 25–398 New movement in Parkinson's.

Lozano AM, Kalia SK. Sci Am. July 2005. Vol.293. No.1. p.58-65.
Reviewed by Dr Ron Vautier
**Review:** Abnormalities in protein-folding and disposal systems appear to be fundamental in Parkinson's disease, and genetic causes for these failures are coming to light.
**Comment:** This is a clearly comprehensive article on an important subject, worth reading even if it does not change anything in the immediate future.

## Nutrition

### 25–399 Stigmatized students: Age, sex, and ethnicity effects in the stigmatization of obesity.

Latner JD, Stunkard AJ, Wilson GT. Obes Res. 1 July 2005. Vol.13. No.7. p.1226-31.
Reviewed by Dr Anne-Thea McGill
**Review:** This US study of 356 university students (56% women, mean age 20.6, BMI 23.3, range 14.4-45kg/m2) extended a done in children ranking on their liking of people who ranged from obese, having a disability or no disability depicted in six drawings. The results took into account participants' BMI, age and ethnicity and showed that the obese person drawing was one of the least liked, with African-American women and Asians showing less bias against them. Obese participants were as stigmatising as the others in the study. Men were more judgmental about obese peers than women. This was a well done study by a well known author, addressing a hidden health issue.
**Comment:** In spite of the accelerating increase in obesity, stigmatisation persists and is highly prevalent in adults, although perhaps less so in ethnic minority members of the population. Interestingly, this study was derived from a child study, but sadly showed little improvement in stigmatisation with maturity and, in fact, health professionals have been shown to show the same trend. No moves to reduce stigmatisation are apparent in schools, workplace or health services – efforts to redress this lack should be made.

### 25–400 Obesity: an overblow epidemic.

Gibbs WW. Sci Am. June 2005. Vol.292. No.6. p.48-55.
Reviewed by Dr Ron Vautier
**Review:** There is no doubt that the prevalence of higher body mass indices is increasing, but now some researchers are arguing that the morbidity and mortality consequences have been exaggerated.
**Comment:** It pays to have some understanding of the limitations of the evidence we feel backs up the advice we offer, and this article helps in this regard.

## Oncology

### 25–401 Benign breast disease and the risk of breast cancer.

Hartmann LC, Sellers TA, Frost MH, et al. N Engl J Med. 21 July 2005. Vol.353. No.3. p.229-37.
Reviewed by Dr Raina Elley
**Review:** Benign breast disease is a risk factor for subsequent malignant breast disease. This has been shown previously. However, this cohort study of 9087 women diagnosed with benign breast disease between 1967 and 1991 at the Mayo clinic, showed that the histology of the benign breast lesion, the age of the women at initial biopsy and strength of family history of breast disease all influence the relative risk. The overall relative risk of any benign breast disease compared with no history of benign breast disease was 1.56 (95%CI. 1.45-1.68). The relative risks for biopsy showing atypia, proliferative changes without atypia, and non-proliferative, were 4.24, 1.88, and 1.27, respectively (all statistically significant). The risk was increased with family history of breast cancer (independent of histological risk association) and higher for those that had benign disease diagnosed at a younger age (e.g. under 40 years). For those diagnosed with non-proliferative benign breast disease with no family history, there was no increased risk of breast cancer.
**Comment:** Interesting cohort study and important information to inform our patients about their risk, especially as breast lump biopsies are becoming more common with the advent of mammography screening.

### 25–402 Rofecoxib for colorectal adenomas increased thrombotic events.

Juurlink D. Evidence-Based Medicine. August 2005. Vol.10. No.4. p.106-7.
Reviewed by Dr Bruce Arroll
**Review:** In the paper by Bresalier, et al. clonidine was studied as part of a systematic review. RCT of Rofecoxib versus placebo. Outcomes included an increase in thrombotic events. Numbers needed to harm (NNH) 55 defined as thrombotic events (fatal and nonfatal MI, unstable angina, sudden death from cardiac causes, fatal and non-fatal ischaemic stroke, TIA, peripheral arterial thrombosis, peripheral venous thrombosis, and pulmonary embolism). An Antiplatelet Trialists' Collaboration (APTC) outcome NNH =68 was also analysed (combined incidence of death from cardiovascular, haemorrhagic, and unknown causes; non-fatal MI; and non-fatal ischaemic and haemorrhagic stroke). In the second paper by Solomon et al. celecoxib 800mg vs placebo NNH 43 and for 400mg vs placebo NNH was not significant. (Original papers reviewed: N Engl J Med 2005; 352:1092-102 & 1071-80)

**Comment:** The commentator suggests 'Recognising that no drug is completely free of risk, it seems sensible to restrict the use of COX 2 inhibitors to a small minority of patients without overt vascular disease who require an anti-inflammatory but are at high risk of gastrointestinal haemorrhage or are intolerant of other NSAIDs. These patients should be apprised of the possible risks and if they consent to treatment, both the dose and duration of therapy should be minimised.' Use of a lower dose of Celecoxib may be safer.

### 25–403 Can we prevent prostate cancer?

Chong P, Rashid P. Aust Fam Physician. April 2005. Vol.34. No.4. p.265-7.
Reviewed by Dr Rachel Monk
**Review:** There is evidence that some nutrients, supplements and dietary changes may reduce prostate cancer risk. If you're keen to have some evidence to present to your patients have a read of this article.

## Paediatrics

### 25–404 What is the best treatment for gastroesophageal reflux and vomiting in infants?

McPherson V, Wright ST, Bell AL. J Fam Pract. April 2005. Vol.54. No.4. p.372-5.
Reviewed by Dr Bruce Adlam
**Review:** The literature on paediatric reflux can be divided into studies addressing clinically apparent reflux (vomiting or regurgitation) and reflux as measured by pH probe or other methods. Formula thickened with rice cereal decreases the number of postprandial emesis episodes in infants with gastroesophageal reflux disease. Use of Carob bean gum has conflicting results, metoclopramide does not alter symptoms but improves weight gain. Carob bean gum used as a formula thickener decreases reflux as measured by intraluminal impedance but not as measured by pH probe. Omeprazole and metoclopramide each improve the reflux index as measured by esophageal pH probe (All strength of recommendations = B).
**Comment:** Data from breast fed infants not presented separately

### 25–405 Can the world afford to save the lives of six million children each year?

Bryce J, Black RE, Walker N, et al. Lancet. 25 June-1 July 2005. Vol.365. No.9478. p.2193-200.
Reviewed by Dr Tony Hanne
**Review:** Ninety per cent of child mortality under five years in the 42 poorest countries could be prevented by the wise spending of an additional US$5.1 billion. Much of this would be needed for clean water and good sanitation. Some specific food supplements would be very helpful. Immunisations would make a big difference. Prevention of malaria and HIV acquired at birth, and antibiotic use in pneumonia and premature rupture of membranes would be very important, as would trained birth attendants.
**Comment:** What are not needed are expensive hospitals, bureaucratic corruption, and more policy analysts. Why do we lack the will to achieve this? (see also 25-406).

### 25–406 Child survival: countdown to 2015.

Bryce J, Victora CG. Lancet. 25 June-1 July 2005. Vol.365. No.9478. p.2153-4.
Reviewed by Dr Tony Hanne
**Review:** See 25-405.

## Prescribing

### 25–407 Prescription drug use and abuse: Risk factors, red flags, and prevention strategies.

Isaacson JH, Hopper JA, Alford DP, et al. Postgrad Med. July 2005. Vol.118. No.1. p.19-25.
Reviewed by Dr Chris Milne
**Review:** This article describes the risk factors, red flags and strategies for prevention. I particularly liked the bit on characteristics of doctors e.g. 'medication mania' (the view that prescribing is the best response to all patient concerns), 'hypertrophied enabling' (having the urge to help patients with all problems), and 'confrontation phobia' (lacking the ability to say no to patients).
**Comment:** Useful article about an important topic. Good tables with red flags for drug seeking by patients, plus strategies to prevent prescription drug abuse.

### 25–408 Influence of patients' requests for direct- to-consumer advertised antidepressants: A randomized controlled trial.

Kravitz RL, Epstein RM, Feldman MD, et al. JAMA. 27 April 2005. Vol.293. No.16. p.1995-2002.
Reviewed by Dr Raina Elley
**Review:** RCT of 298 actor visits with 'major depression' or 'adjustment disorder' made to 152 family physicians. These standardised visits were randomised to request for a brand specific Paroxetine, request for general medication or no request for medication. With major depression the antidepressant prescribing rates were 53%, 76% and 31% respectively. The specific brand of paroxetine (which was more expensive than the currently available generic fluoxetine) was prescribed in 27%, 2% and 4% of visits, respectively. For adjustment disorder consultation resulted in a prescription for antidepressants in 55%, 39% and 5% of visits, with the brand paroxetine prescribed in 18%, 5% and 0% of visits, respectively. 'Minimally acceptable initial care' for the major depression case (i.e. received antidepressant, mental health referral or follow-up within two weeks) was offered in 90%, 98% and 56%, respectively. (All reported results were statistically significant $p<0.001$)
**Comment:** One for Les Toop. This is a great study and shows us how patient requests, and DTC advertising

if it affects patient requests, can have a substantial impact on prescribing patterns and management – perhaps detrimental over and above unnecessary extra costs. See also 25-409.

**25-409 Direct-to-consumer advertising: A haphazard approach to health promotion.**

Hollon MF. JAMA. 27 April 2005. Vol.293. No.16. p.2030-3.

Reviewed by Dr Raina Elley

**Review:** See 25-408.

## Preventive Medicine and Screening

**25-410 False-positive PSA associated with increased worry and fears.**

J Fam Pract. April 2005. Vol.54. No.4. p.303.

Reviewed by Dr Bruce Adlam

**Review:** False-positive results of screening tests are not benign; they have a psychological cost. Men who received false-positive PSA test results reported having thought and worried more about prostate cancer despite receiving a negative follow-up (prostate biopsy) result. They also think that the false-positive result makes them more likely to develop prostate cancer. Screening can be bad for our patients' mental health. (Level of evidence (Level of Evidence =1b). (Original article reviewed: Am J Med 2004; 117:719-25)

**Comment:** On the surface there appears to be some methodological flaws in this study arising from the construction of the questionnaire and the choosing of the controls.

**25-411 Use of community genetic screening to prevent HFE-associated hereditary haemochromatosis.**

Delatycki MB, Allen KJ, Nisselle AE, et al. Lancet. 23-29 July 2005. Vol.366. No.9482. p.314-6.

Reviewed by Dr Tony Hanne

**Review:** Screening in the workplace by cheek – brushing identified 47 individuals among a population of 11 000 who were homozygous for hereditary haemochromatosis. All but one accepted treatment. Several were found to have already sustained liver damage. Many of those who tested positive had already reported symptoms of tiredness. Particular attention was given to considering whether screening produced anxiety about a previously undiscovered abnormality but no evidence of this was found.

**Comment:** A good argument can be made for such routine screening for a condition with a roughly 0.5% incidence which can be simply and cheaply treated. This is strengthened by the genetic nature of the problem which means that finding one case may lead to a family cluster of further cases. A bonus lies in the safety of using blood taken from affected individuals for transfusion. Everyone wins! See also 25-412.

**25-412 Screening for haemochromatosis – producing or preventing illness?**

Adams PC. Lancet. 23-29 July 2005. Vol.366. No.9482. p.269-71.

Reviewed by Dr Tony Hanne

**Review:** See 25-411.

## Procedures and Techniques

**25-413 Buying time in suspended animation.**

Roth MB, Nystul T. Sci Am. June 2005. Vol.292. No.6. p.24-31.

Reviewed by Dr Ron Vautier

**Review:** Hydrogen sulphide is produced naturally by our bodies, and appears to be a regulator of cellular oxidative energy production. Some organisms completely shut down in situations of absent oxygen, then can fully revive. Understanding what is involved may lead to better donor organ preservation and injury victim recovery.

**Comment:** Certainly an intriguing article.

**25-414 How does tissue adhesive compare with suturing for superficial lacerations?**

Aukerman DF, Sebastianelli WJ, Nashelsky J. J Fam Pract. April 2005. Vol.54. No.4. p.378.

Reviewed by Dr Bruce Adlam

**Review:** In this systematic review of randomised trials, tissue adhesives are effective and yield results comparable to those with conventional suturing of superficial, linear, and low-tension lacerations. The cosmetic outcome is similar and wound complications may be lower with tissue adhesives. It's also quicker, less painful and follow-up for removal of sutures is not needed.

**Comment:** Perhaps this is a reasonable trade off for the higher cost.

## Psychiatry and Psychology

**25-415 What are effective treatments for oppositional and defiant behaviors in preadolescents?**

Farley SE, Adams JS, Lutton ME, et al. J Fam Pract. February 2005. Vol.54. No.2. p.162, 64-5.

Reviewed by Dr Bruce Adlam

**Review:** This extensive literature review suggests parent training is effective for treating oppositional and defiant behaviors [Strength of recommendation A]. Parent training programmes are standardised, short-term interventions that teach parents specialised strategies – including positive attending, ignoring, the effective use of rewards and punishments, token economies, and time out – to address clinically significant behaviour problems. In addition to parent training, other psychosocial interventions are efficacious in treating oppositional and defiant behaviour. To date, no studies have assessed the efficacy of medication in treating children with pure oppositional defiant disorder (ODD). However, studies have shown amphetamines to be effective for children with ODD and comorbid attention deficit/hyperactivity disorder (ADHD). (Strength of recommendation A).

**Comment:** Good base for review, or for further study in NZ context. Con-

tains a balanced commentary that acknowledges parents often want a 'quick fix' in a consultation that is usually time consuming and requires considerable participation in the solution on their part.

**25-416 What is the most effective treatment for ADHD in children?**

Johnson LA, Safranek S. J Fam Pract. February 2005. Vol.54. No.2. p.166-8.

Reviewed by Dr Bruce Adlam

**Review:** This review suggests stimulant medication therapy (A Table is supplied) is the most effective treatment for attention deficit/hyperactivity disorder (ADHD) in children, producing significant improvements in symptoms and modest improvements in academic achievement (strength of recommendation: A). Non-pharmacologic therapies, such as behaviour therapy, school- based interventions, and family therapy, are not as effective as stimulants but may add modest benefit to the effects of medication (SOR: B).

**Comment:** Useful updates on alternative stimulant medication and combinations with clonidine. Views of others and a clinical commentary follows.

**25-417 Recognition and optimal management of schizophrenia and related psychoses.**

Singh B. Intern Med J. July 2005. Vol.35. No.7. p.413-8.

Reviewed by Dr Helen Moriarty

**Review:** A selective but comprehensive review of the current state of knowledge on schizophrenia. This paper presents the scientific mental health viewpoint on diagnosis, prognosis, outcomes, aetiology and treatments including early intervention and outreach for the hard-to-reach, including the homeless.

**Comment:** An interesting omission was the cultural and societal view on schizophrenia. When are the symptoms accepted and when is the treatment optional? This is merely touched upon as 'diagnostic uncertainty' – but is more deserving than that!

**25-418 Pathologic gambling disorder: How to help patients curb risky behavior when the future is at stake.**

Sumitra LM, Miller SC. Postgrad Med. July 2005. Vol.118. No.1. p.31-7.

Reviewed by Dr Chris Milne

**Review:** This article gives a good overview of a problem that is commoner than we think. It is also treatable, provided our patients are recognised, and get the right expert assistance. Includes a useful mnemonic for diagnosing pathologic gambling disorder – WAGER OFTEN – read the article to see what these stand for.

**Comment:** The article considers pathologic gambling disorder represents a model of lack of impulse control, and is therefore ideal for future neurobiological research.

**25-419 Paternal depression in the postnatal period and child development: a prospective population study.**

Ramchandani P, Stein A, Evans J, et al. Lancet. 25 June-1 July 2005. Vol.365. No.9478. p.2201-5.

Reviewed by Dr Tony Hanne

**Review:** It has long been recognised that maternal post-natal depression affects childhood development in early years but it seems no-one has asked before whether depressed fathers might hinder early development. This very large study of over 12 000 fathers and 13 000 mothers looked for depression at eight weeks after the birth of their children and again at 21 months. About 300 fathers showed significant depression while some 1200 mothers also were depressed. The children were assessed at 3.5 years for behavioural and emotional problems. The boys were more than twice as likely to be having difficulties, particularly conduct problems, if their fathers were depressed. There was little effect on the girls of paternal depression.

**Comment:** This fascinating study adds to the growing awareness of what common sense has long told us, that fathers do matter in boys' development. Each parent makes a unique contribution to a child's life from the very beginning. Social engineering, which assumes that two parents of different genders are only one of a range of good options, is dangerous. What is not clear in this research is the extent to which parental post-natal depression is the result of an already struggling relationship. (see also 25-420).

**25-420 Paternal postnatal depression: fathers emerge from the wings.**

Solantaus T, Salo S. Lancet. 25 June-1 July 2005. Vol.365. No.9478. p.2158-9.

Reviewed by Dr Tony Hanne

**Review:** See 25-419.

## Respiratory System

**25-421 Information leaflet and antibiotic prescribing strategies for acute lower respiratory tract infection: A randomized controlled trial.**

Little P, Rumsby K, Kelly J, et al. JAMA. 22/29 July 2005. Vol.293. No.24. p.3029-35.

Reviewed by Dr Raina Elley

**Review:** RCT of immediate antibiotics versus delayed prescription of antibiotics versus no offer of antibiotics amongst 807 patients with acute LRTI (without focal signs) recruited from primary care. While 96% of those in the first group had antibiotics, 20% and 16% received them in the other groups, respectively. There was no difference in duration of cough or severity of symptoms between the groups. Amongst secondary outcomes, only duration of moderately bad symptoms improved with immediate antibiotics and there were lower rates of reattendance within a month with immediate antibiotics. This trial also used a factorial design where half of each group was randomly allocated to receive an information pamphlet or not. The pamphlet made no

difference to primary or secondary outcomes.
**Comment:** Previous Cochrane reviews have shown a marginal benefit for antibiotics in acute LRTI. This RCT had more subjects than any previous trials and showed no clear benefit to cough duration or overall symptom severity, which is an important finding. There was one person in the control group who developed pneumonia and required hospitalisation. This is always the risk of not using antibiotics at all in this group, albeit small if you look at the numbers. One criticism of the trial was that they only analysed results from the 640/807 (80%) that they had follow-up results on. The results of the other 20% may have altered the true results and an intention to treat analysis might have been more appropriate. (see also 25-422)

**25–422 Antibiotic prescribing for cough and symptoms of respiratory tract infection: Do the right thing.**
Ebell MH. JAMA. 22/29 June 2005. Vol.293. No.24. p.3062-4.
Reviewed by Dr Raina Elley
**Review:** See 25-421.

## Rheumatic Diseases

**25–423 Acupuncture effective for osteoarthritis of the knee.**
J Fam Pract. March 2005. Vol.54. No.3. p.200.
Reviewed by Dr Bruce Adlam
**Review:** Acupuncture, as compared with sham acupuncture treatment or no treatment, decreases pain scores by an average of 40% and improves function similarly in patients who stick with it. The acupuncture used in this study was based on the Traditional Chinese Medicine meridian theory and was used for the entire six months of the study. (Level of evidence =1b) (Original article reviewed: Ann Intern Med 2004; 141: 901-10).
**Comment:** This is the largest and most rigorous study to date of the effect of acupuncture in the treatment of osteoarthritis.

## Sexually Transmitted Diseases

**25–424 Can chlamydia be stopped?**
Ojcius DM, Darville T, Bavoil PM. Sci Am. May 2005. Vol.292. No.5. p.54-61.
Reviewed by Dr Ron Vautier
**Review:** This article provides an excellent description of how the chlamydia bacterium disguises itself inside cells and thus avoids immune recogntion. With more knowledge of the biology involved should come more effective strategies for preventing and treating the diseases that chlamydiae cause.
**Comment:** We need to know more about chlamydiae, and this article can help many of us to this end.

## Sports and Sports Medicine

**25–425 To every thing there is a season.**
McCrory P. Br J Sports Med. 1 July 2005. Vol.39. No.7. p.409.
Reviewed by Dr Chris Milne
**Review:** The author is one of the most-published people I know. Here, he analyses the art of conference-going, with reference to Shakespeare's *'As you like it'*. He describes the problems of huge American mega-meetings, with the ability to get to only a small minority of presentations. There are also some pithy observations on computer glitches, and the seven ages of man.
**Comment:** A good read if, like me, you're in mid career, and want a wry look at conference-going. His parting tip – stay in the coffee shop and enjoy the process.

**25–426 A systematic review and meta-analysis of clinical trials on physical interventions for lateral epicondylalgia.**
Bisset L, Paungmali A, Vicenzino B, et al. Br J Sports Med. 1 July 2005. Vol.39. No.7. p.411-22.
Reviewed by Dr Chris Milne
**Review:** There are over 500 published articles on treatment of tennis elbow. This is a systematic review of 28 randomised trials that satisfied at least eight of 15 quality criteria. Most of these trials involved small numbers of patients (median sample size of 21 per group). The main finding was that extra corporeal shock wave therapy is not helpful, and occasionally produces adverse effects. The best single trial showed that cortico-steroid injections are more effective than physiotherapy in the short term, but physiotherapy is more effective than injections in the longer term.
**Comment:** At present, I'd recommend an injection if there is a lot of inflammatory pain, followed by a progressive concentric then eccentric exercise programme.

**25–427 Incidence of serious injury and death during sport and recreation activities in Victoria, Australia.**
Gabbe BJ, Finch CF, Cameron PA, et al. Br J Sports Med. 1 August 2005. Vol.39. No.8. p.573-7.
Reviewed by Dr Chris Milne
**Review:** Death whilst participating in sport or recreation is (fortunately) a rare event. In this Victorian study there were 150 cases of serious injury and 48 deaths in a two year period. Motor, power boat and equestrian events had the highest risk of serious injury. Most deaths were due to drowning.
**Comment:** Most of the published data on this topic has come out of North America. It is good to have access to data from closer to New Zealand. The message is – respect the water and mechanised sports.

## Therapeutics

**25–428 A toxin against pain.**
Stix G. Sci Am. April 2005. Vol.292. No.4. p.70-5.
Reviewed by Dr Ron Vautier

**Review:** Five hundred species of cone snail are known to produce 50 000 peptide toxins, a number of which show considerable potential in pharmaceutical products, particularly analgesics. This article reviews a little of the historical development and pharmacology involved.
**Comment:** This should be enjoyed by a small proportion of doctors for its intrinsic interest, but is otherwise not of much importance.

## Travel Medicine

### 25-429 Traveller's diarrhoea.

Kass B. Aust Fam Physician. April 2005. Vol.34. No.4. p.243-7.
Reviewed by Dr Rachel Monk

**Review:** This is a very common problem amongst travellers and hasn't changed much over the years despite education around safe eating/drinking. This article not only focuses on prevention but also treatment of traveller's diarrhoea.
**Comment:** The flow chart on page 245 would be a useful resource to provide potential traveller's with.

## Urology

### 25-430 Cost-effective management for nephrolithiasis.

J Fam Pract. February 2005. Vol.54. No.2. p.113.
Reviewed by Dr Bruce Adlam

**Review:** In this cost effective analysis patients with first-time kidney stones, conservative therapy (dietary modification only) is the most cost-effective strategy. In recurrent stone formers, both empiric therapy (dietary modification and potassium citrate) and a modified simple metabolic evaluation (one 24-hour urine collection for renal stone risk factors, with both potassium citrate and hydrochlorothiazide for patients with hypercalciuria, and potassium citrate alone for patients with normocalciuria) are equally cost-effective. (Level of evidence =2b) (Original article reviewed: J Urology 2004; 172: 2275-81.)

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**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

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