Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Am Fam Physician*
Am J Clin Nutr*
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Intern Med J*
J Fam Pract*
J Voice*
Lancet*
NeuroImage*
Obesity*
Pain*
Sci Am*
*Journals indexed in Medline

Acupuncture

26–359 Meta-analysis: Acupuncture for low back pain

Manheimer E, White A, Berman B, et al. Ann Intern Med. April 2005. Vol.142. No.8. p.651-63.

Reviewed by Dr Alex Chan

Review: Thirty-three randomised control trials were included in this most recent meta-analysis. Acupuncture was found to be effective in the treatment of chronic low back pain in both short and long-term effects. The results of this study differ from those of the Cochrane Review of acupuncture for low back pain, which did not find acupuncture to be effective. This could be the result of the inclusion of more recent high quality trials and also the combination of trials in the meta-analysis, which the authors considered to be more objective than a strictly qualitative approach as used in some other reviews.

Comment: Evidence does change. Everyone should keep an open mind on the evidence presented at any particular time. While acupuncture was shown to be effective in the management of chronic low back pain, the claim could only be a modest one as there was no evidence that acupuncture was better than any other treatment. However, it could be an option which should be taken into consideration in the overall management of patients with chronic low back pain.

26–360 A randomized treatment–placebo study of the effectiveness of acupuncture for benign vocal pathologies

Yiu E, Xu JJ, Murry T, et al. J Voice. March 2006. Vol.20. No.1. p.144-56.

Reviewed by Dr Alex Chan

Review: This is a randomised control trial on the effect of acupuncture in the treatment of dysphonias associated with benign pathological changes including vocal nodules, vocal polyps, and vocal fold thickening. In the treatment group, the acupoints ST-9, LU-7, and K-6 were needled bilaterally, with electrical stimulation to ST-9, while in the placebo group, SI-3 and BL-60 were needled bilaterally. Ten sessions were given within a 20-day period. Significant improvement was shown in the treatment group when assessed with acoustic analysis of voice range profile, perceptual analysis of voice quality, and self-perceptions of quality-of-life measurements. Physical reduction in vocal mass lesions was also noted in the treatment group by a blinded laryngologist using indirect laryngoscopy.

Comment: A significant study in which the placebo group received real acupuncture to selected acupoints, which were not supposed to have effects on the larynx. A weakness of the study was that 54 subjects were initially recruited but only 24 completed the trial because of attrition. The reasons and characteristics of those who discontinued the trial were not detailed in the paper.

26-361 The integrated response of the human cerebro-cerebellar and limbic systems to acupuncture stimulation at ST 36 as evidenced by fMRI

Hui KK, Liu J, Marina O, et al. NeuroImage. September 2005. Vol.27. No.3. p.479-96.
Reviewed by Dr Alex Chan

Review: A detailed study of the cerebro-cerebellar and limbic systems response to manual needling of the acupoint ST-36. A concerted attenuation of signal intensity was noted in the cerebro-cerebellar and limbic systems in subjects who experience the deqi sensation during acupuncture, but an increase in signal intensity was noted in those who experience sharp pain in addition to deqi. (Deqi sensation is a sensation around the needling site various described as pressure, fullness, aching, heaviness, numbness and tingling.) From their findings, the authors postulated that neuromodulators, in particular dopamine, might play an important role in the psychophysical response to acupuncture.
Comment: An interesting study which, for the first time, showed the neural correlates of deqi. It also showed that the cerebellum, in addition to the cerebrum and limbic systems, played a part in the response of the body to acupuncture.

26-362 Effects of intensity of electroacupuncture upon experimental pain in healthy human volunteers: a randomised, double-blind, placebo-controlled study

Barlas P, Ting SL, Chesterton LS, et al. Pain. May 2006. Vol.122. No.1-2. p.81-9.
Reviewed by Dr Alex Chan

Review: This study compared the pressure pain thresholds in subjects assigned to four groups: control, placebo electroacupuncture (EA), high intensity EA and low intensity EA of low frequency (4Hz). It confirmed that high intensity EA to the dominant forearm and ipsilateral leg had significantly larger analgesic effects in both dominant and non-dominant hands than low-frequency low intensity EA or placebo stimulation. No significant differences were observed between the control and placebo groups.
Comment: For those who are interested in doing some research in acupuncture, this is an excellent study, which is well worth reading.

26-363 Redefining the randomized controlled trial in the context of acupuncture research

Walji R, Boon H. Complement Ther Clin Prac. May 2006. Vol.12. No.2. p.91-6.
Reviewed by Dr Alex Chan

Review: This is a proposal for a different approach in designing randomised controlled trials (RCTs) in acupuncture. The authors proposed that inclusion criteria should be defined according to both conventional and traditional TCM diagnosis to ensure homogeneity across groups; standardised diagnostic parameters and therapeutic approaches but allowing individual variability in treatment protocols; single blinding by the use of technically modified needles; and the use of both control and sham groups.
Comment: This was an intellectual exercise by the authors to modify RCT designs for acupuncture research. It may not be perfect, but at least this is a starting point for further development and refinement.

26-364 Influence of acupuncture stimulation on pregnancy rates for women undergoing embryo transfer

Smith C, Coyle M, Norman RJ. Fertil Steril. May 2006. Vol.85. No.5. p.1352-8.
Reviewed by Dr Alex Chan

Review: This single blind, randomised controlled trial examined the effect of acupuncture versus sham acupuncture on clinical pregnancy rates for 228 women undergoing embryo transfer (ET). Treatment was given on day nine of stimulating injections, the second before ET, and the third immediately after ET. No significant difference in the pregnancy rate was found between groups although the pregnancy rate was higher in the acupuncture group when compared with the placebo group (31% vs 23%) and the ongoing pregnancy rate at week 18 was also higher in the acupuncture group (28% vs 18%).
Comment: Sham acupuncture was performed using the Streitberger placebo needle. Sham acupuncture points were located close to but not on the real acupuncture points. Quite a number of acupuncture studies so far showed no significant difference between active and placebo acupuncture. Future trials comparing active acupuncture, placebo acupuncture and no acupuncture groups would give further insights into the effect of acupuncture and placebos in non-pain related conditions.

26-365 Acupuncture on the day of embryo transfer significantly improves the reproductive outcome in infertile women: a prospective, randomized trial

Westergaard LG, Mao Q, Krogslund M, et al. Fertil Steril. May 2006. Vol.85. No.5. p.1341-6.
Reviewed by Dr Alex Chan

Review: This prospective randomised trial also examined the effect of acupuncture on reproductive outcome in 273 patients treated with IVF/intracytoplasmic sperm injection (ICSI). It was found that acupuncture on the day of embryonic transfer (ET) significantly improved the rates of positive pregnancy test results (42% vs 28%), clinical pregnancies (39% vs 24%) and ongoing pregnancies or delivery (36% vs 22%) comparing to no acupuncture. The benefit was mainly confined to patients younger than 38 years. However, additional acupuncture two days after embryonic transfer did not provide any additional effect.

Comment: This study used a standard acupuncture prescription for all patients – DU20, ST29, SP8, PC6 and LR3 before ET, and ST36, SP6, SP10, and LI4 after ET. Placebo acupuncture was not used as control.

Alcohol and Substance Abuse

26–366 Recreational ecstasy use and the neurotoxic potential of MDMA: current status of the controversy and methodological issues

Lyvers M. Drug Alcohol Rev. May 2006. Vol.25. No.3. p.269-76.

Reviewed by Dr Helen Moriarty

Review: Ecstasy is MDMA, a stimulant with hallucinogenic properties. Surveys in Australia show 20% aged 20–29 years have used it, usually in club settings. Animal models have shown neurotoxicity, which is controversial in humans. Cognitive defects are confounded by concurrent cannabis use. This paper discusses the dilemma of researching such substances in the light of user behaviour and public policy pressures.

Comment: New Zealand surveys also show use is common in this age group. A good read; it ends with the tantalising question *'Do we want ecstasy to cause brain damage?'*

Alcohol Drinking

26–367 Prospective study of alcohol drinking patterns and coronary heart disease in women and men

Tolstrup J, Jensen MK, Tjonneland A, et al. BMJ. 27 May 2006. Vol.332. No.7552. p.1244-8.

Reviewed by Dr Len Brake

Review: It is well known but generally kept fairly low key that alcohol intake is inversely associated with the risk of coronary artery disease. In men frequent drinkers have a lower risk than the less frequent drinker. This study suggests that intake may be more important than frequency of drinking for the similar inverse association in women. In men the frequency is more important than the alcohol intake. Various reasons are pondered but the article advises caution in giving public health advice on the subject.

Cardiovascular System

26–368 How effective are lifestyle changes for controlling hypertension?

Lochner J, Rugge B, Judkins D. J Fam Pract. January 2006. Vol.55. No.1. p.73-4.

Reviewed by Dr Bruce Adlam

Review: Regular aerobic exercise, weight loss of 3% to 9% of body weight, reduced dietary salt, the DASH diet and moderation of alcohol intake are all lifestyle interventions that lower blood pressure. Average blood pressure decreases range from 3 to 11 mm Hg systolic and 2.5 to 5.5 mm Hg diastolic, depending on the particular intervention (strength of recommendation: A, based on systematic reviews of randomised controlled trials [RCTs]).

Comment: The bottom line is that lifestyle modifications plus drug therapy is the best treatment for patients with hypertension. The DASH diet is rich in fish, chicken, lean meat, low-fat dairy, fruits, vegetables, whole grains, legumes, nuts, and seeds.

26–369 Symptomatic and asymptomatic carotid stenosis: just when we thought we had all the answers

Gates PC, Chambers B, Yan B, et al. Intern Med J. July 2006. Vol.36. No.7. p.445-51.

Reviewed by Dr Helen Moriarty

Review: Carotid endarterectomy is now just one option in treatment of carotid stenosis, which includes angioplasty and stenting. Endarterectomy is of proven advantage for symptomatic carotid stenosis >50%, and angioplasty reserved for those with inaccessible carotids (due to scarring or high bifurcation). An RCT is in progress to indicate the relative efficacy of stenting versus surgery in severe symptomatic stenosis (CAVATAS 2). A current RCT has shown that stroke risk with carotid artery angioplasty increases with age and lung or kidney disease.

Comment: Watch this space.

26–370 Caffeine intake does not increase risk of hypertension in women

J Fam Pract. February 2006. Vol.55. No.2. p.101.

Reviewed by Dr Bruce Adlam

Review: Habitual caffeine consumption does not appear to increase the risk of hypertension in women. In particular, coffee and tea are not associated with increased risk. The development of hypertension is, however, significantly associated with the intake of cola drinks, including both sugared and diet versions. (Level of evidence =2b Prospective Cohort Study.) (Origi-

nal article reviewed: JAMA 2005; 294:2330-5. 141:1093-9).

Communicable Diseases, Infections and Parasites

26-371 Pertussis: a disease affecting all ages

Gregory DS. Am Fam Physician. 1 August 2006. Vol.74. No.3. p.420-6.
Reviewed by Dr Andrea Steinberg
Review: Although childhood vaccination has dramatically reduced reported pertussis cases, the incidence of the disease has increased over the past 20 years, most notably in previously immunised adolescents and adults, whose immunity has decreased and have become reservoirs for pertussis infection. Although pertussis vaccination has significantly reduced reported pertussis rates, its protectiveness is short-lived and incomplete. Immunity begins to decline four to 12 years after vaccination, causing adolescent and adult susceptibility. Therefore, neonates are susceptible to pertussis infection because they have not yet been immunised and they receive little passive immunity from their susceptible mothers. Pertussis should be suspected in patients of all ages with cough who meet the clinical criteria for the disease. The CDC recommends testing and treating patients with clinical or probable pertussis regardless of test results. Testing, treatment, and notification should be considered in patients of all ages presenting with a cough lasting more than two weeks that develops a paroxysmal quality, inspiratory whooping, or post-tussive emesis; and in infants with severe cough, apnoea, or bradycardia for any length of time. The CDC recommends erythromycin, azithromycin, or clarithromycin as preferred agents. Trimethoprim/sulfamethoxazole has been shown to reduce pertussis transmission and is an alternative treatment for patients who are allergic to macrolides.
Comment: An increasingly significant primary care problem. This article contains a useful table with CDC clinical criteria for diagnosis. Take home message is: don't wait for lab test diagnosis before instituting treatment for a clinically suspected case. (Patient information sheet attached). (For editorial comment see 26-372).

26-372 Preventing pertussis in infants by vaccinating adults

Finger R, Shoemaker J. Am Fam Physician. 1 August 2006. Vol.74. No.3. p.382.
Reviewed by Dr Andrea Steinberg
Review: See 26-371.

Dermatology

26-373 Effective prevention and treatment of contact dermatitis

J Fam Pract. February 2006. Vol.55. No.2. p.100.
Reviewed by Dr Bruce Adlam
Review: Barrier creams, high-lipid-content moisturizing creams, fabric softeners, and cotton glove liners are effective for preventing irritative contact dermatitis. Rhus dermatitis can be reduced or prevented with bentonite clay lotion and a topical skin protectant. Chelating creams exist and are effective in preventing nickel, chrome, and copper dermatitis. Steroid preparations are effective in the treatment of both irritative and contact dermatitis. (Level of evidence = 1a- systematic review) (Original article reviewed: J Am Acad Dermatol 2005; 53:845-55).

26-374 Seborrheic dermatitis: an overview

Schwartz RA, Janusz CA, Janniger CK. Am Fam Physician. 1 July 2006. Vol.74. No.1. p.125-37.
Reviewed by Dr Andrea Steinberg
Review: This is a nice refresher on this common primary care problem, usually easy to diagnose, though sometimes presents atypically and may be most confusing! Differential diagnoses include atopic dermatitis, candidiasis, dermatophytoses, Psoriasis, rosacea, SLE, and Langerhans cell histiocytosis.
Comment: It is sometimes frustrating not to be able to offer a curative therapy to what is often a life-long problem.

Diagnosis

26-375 'Elementary, my dear Watson'

McCrory P. Br J Sports Med. April 2006. Vol.40. No.4. p.283-4.
Reviewed by Dr Chris Milne
Review: This editorial uses a study about missing teaspoons in a university department to impart some sage advice for clinicians derived from Sherlock Holmes – knowledge, logical reasoning and experience. The final quality is the ability to reuse a working diagnosis in the light of new information as it becomes available. By the way – the most likely explanation for the disappearance of the spoons was that they had been 'stolen' by staff members.
Comment: This is a superb editorial, and should be read by all clinicians, and also those in health management positions. It explains clearly why there is no real substitute for experienced clinicians spending time with patients in an effort to get to the truth.

Ear, Nose and Throat

26-376 Intranasal steroids alone effective for acute uncomplicated sinusitis

J Fam Pract. March 2006. Vol.55. No.3. p.190.
Reviewed by Dr Bruce Adlam
Review: Intranasal steroids used with antibiotics are more effective in the treatment of recurrent sinus infections than antibiotics alone. The benefit of intranasal steroids alone for uncomplicated sinusitis is uncertain. The vast majority of patients with acute uncomplicated rhinosinusitis improve in two to four weeks without any specific treatment. Treatment with mometasone furoate nasal spray

200 mcg twice daily significantly reduces the time to resolution compared with amoxicillin alone or placebo. (LOE=1b RCT double blind) (Original article reviewed: J Allergy Clin Immunol 2005; 116: 1289-95).
Comment: The authors advise *'patients who feel the need to do something may still find it easier and cheaper to try other modalities such as nasal saline'* although there was no saline group in this study.

Emergency Medicine

26-377 Anaphylaxis: clinical concepts and research priorities

Brown SG. Emerg Med Australas. April 2006. Vol.18. No.2. p.155-69.
Reviewed by Dr Jocelyn Tracey
Review: An overview of the clinical presentation, differential diagnosis, causes, and pathophysiology followed by an overview of treatment. A very helpful algorithm for the management of anaphylaxis is also included.
Comment: Useful for all general practitioners and accident and medical doctors; request a copy of the article and laminate the algorithm. (For the editorial comment see 26-378).

26-378 Anaphylaxis: persistent enigma

Sampson HA. Emerg Med Australas. April 2006. Vol.18. No.2. p.101-2.
Reviewed by Dr Jocelyn Tracey
Review: See 26-377.

26-379 Fingertip injuries

de Alwis W. Emerg Med Australas. June 2006. Vol.18. No.3. p.229-37.
Reviewed by Dr Jocelyn Tracey
Review: The results of a literature review into the assessment and management options for finger tip injuries is presented in a very practical manner. Included are details of transport of amputated parts, treatment of subungual haematomas and management of pulp defects.
Comment: Useful for all general practitioners and accident and medical doctors.

Eye Diseases

26-380 Cataract and surgery for cataract

Allen D, Vasavada A. BMJ. 15 July 2006. Vol.333. No.7559. p.128-32.
Reviewed by Dr Len Brake
Review: Cataract surgery is the commonest single surgical procedure carried out in the developed world. In the developing world, cataract remains the commonest cause of blindness. These are two of the statements in the first paragraph of this very readable and up-to-date clinical review.
Comment: Thoroughly recommended.

Family Practice

26-381 The acceptability of routine inquiry about domestic violence towards women: a survey in three healthcare settings

Boyle A, Jones PB. Br J Gen Pract. April 2006. Vol.56. No.525. p.258-61.
Reviewed by Dr Siva Nachiappan
Review: An interview-based cross-sectional study by Boyle et al. (2006) shows that most women were not offended by questioning about domestic violence. There was a strong association of finding questioning unacceptable from women who were abused within one year but not for lifelong abuse.
Comment: The setting of this study was at three general practice surgeries, one antenatal clinic and one emergency department in Cambridge, England. The questions used was *'Have you been hit, kicked, punched or otherwise hurt by a partner or ex-partner in the last year?'*

Gastroenterology

26-382 Dyspepsia management guideline

J Fam Pract. February 2006. Vol.55. No.2. p.99-100.
Reviewed by Dr Bruce Adlam
Review: This evidence-based guideline summarises the best approach to the evaluation and treatment of patients with dyspepsia, defined as chronic or recurrent pain in the upper abdomen. (Original article reviewed: Am J Gastroenterol 2005; 10: 2324-37).
Comment: Don't forget NZ's own dyspepsia guidelines available on the New Zealand Guidelines Group website (www.nzgg.org.nz).

26-383 COX-2 inhibitor no safer than naproxen and PPI

J Fam Pract. March 2006. Vol.55. No.3. p.192.
Reviewed by Dr Bruce Adlam
Review: In patients at high risk for recurrent peptic ulcer with nonsteroidal anti-inflammatory drug (NSAID) therapy, celecoxib was no more effective than the combination of naproxen (Naprosyn) and lansoprazole (Prevacid) in preventing serious adverse effects and was more likely to cause dyspepsia symptoms. The benefit of cyclooxygenase-2 (COX-2) inhibitors in preventing serious gastrointestinal adverse events is likely overstated. (Level of evidence =1b- RCT (non blinded)) (Original article reviewed: Am J Med 2005; 118: 1271-8).
Comment: A similar study found no difference in adverse events comparing celecoxib with diclofenac plus omeprazole (Gastroenterology 2004; 127: 1038-43).

General

26-384 Editoral piece

Turner M. Br J Sports Med. June 2006. Vol.40. No.6. p.488.
Reviewed by Dr Chris Milne
Review: This editorial is reproduced by permission of Roy Baumeister, who published it in the *American Journal of Radiology* on April Fool's Day in 1992. It is a tongue-in-cheek response to an editor by an anguished author.
Comment: A superb rendition of the frustration suffered by all authors from time to time, when confronted by asinine suggestions from reviewers.

26-385 Effects of self-reported racial discrimination and deprivation on Maori health and inequalities in New Zealand: cross-sectional study

Harris R, Tobias M, Jeffreys M, et al. Lancet. 17-23 June 2006. Vol.367. No.9527. p.2005-9.
Reviewed by Dr Tony Hanne

Review: This is a Ministry of Health led study into how New Zealanders see their experience of racial discrimination and its possible effect on health. The only two groups studied were Maori and European and showed marked differences in perceived discrimination particularly in relation to issues such as housing and to a lesser extent in work and health. Maori reported far higher levels of verbal and somewhat higher physical attacks. The assumption is made that because health statistics for Maori are poorer, such discrimination is a major cause of poorer health especially because of higher levels of self abuse with smoking and alcohol. The lesson is drawn that addressing racial discrimination would help to improve health in Maori.

Comment: There are some weaknesses in logic in this paper. Firstly the questions are about perception of discrimination. Is it not almost inevitable that a minority will feel discriminated against simply because they are a minority? Secondly without asking the subjects whether they are in some way turning hurt over race into damaging behaviour how can the conclusion be drawn that discrimination damages health? Thirdly does a government addressing racial discrimination change such attitudes? (For commentary see 26-386).

26-386 Racism, socioeconomic deprivation, and health in New Zealand

Bhopal R. Lancet. 17-23 June 2006. Vol.367. No.9527. p.1958-9.
Reviewed by Dr Tony Hanne

Review: See 26-385.

Genetics

26-387 The real life of pseudogenes

Gerstein M, Zheng D. Sci Am. August 2006. Vol.295. No.2. p.30-7.
Reviewed by Dr Ron Vautier

Review: Pseudogenes look almost like normal genes, but in most cases are copies of the actual protein-coding genes, which have been damaged through mutations and shunted aside in the genome. They are in effect genetic fossils, and thus provide insight into gene evolution and genome dynamics. In particular, evidence now shows that a large part of them are in fact transcribed into RNA, possibly playing a part in regulating the activity of the normal genes.

Comment: This is a fascinating article. The so-called 'junk DNA' is turning out to be not so at all.

Gynaecology

26-388 Uterine artery embolisation: A treatment alternative for women with fibroids

Lyon SM, Cavanagh. Aust Fam Physician. May 2006. Vol.35. No.5. p.300-3.
Reviewed by Dr Mary Tucker

Review: Fibroids are a common benign tumour of the female reproductive tract. Therapeutic options including hysterectomy and uterus sparing techniques, which include the use of gonotropin releasing hormone, myomectomy, hysteroscopic resection and endometrial ablation are discussed. Uterine artery embolisation is a minimally invasive, catheter based technique that compares favourably with surgical treatments and is especially relevant to women who wish to preserve their uterus. Menorrhagia resolves or is significantly reduced. Fertility rates following this procedure are similar to those following myomectomy.

Comment: Hospital stays are usually less than 48 hours, women are usually able to return to normal activities within 14 days, and are generally satisfied with the result of the procedure.

26-389 Improving women's experience during speculum examinations at routine gynaecological visits: randomised clinical trial

Seehusen DA, Johnson DR, Earwood JS, et al. BMJ. 22 July 2006. Vol.333. No.7560. p.171-3.
Reviewed by Dr Len Brake

Review: In the USA it is routine to do speculum vaginal examinations with the woman in stirrups. This includes simple vaginal examinations and cervical smears. Stirrups and the subsequent lithotomy position makes the woman feel more vulnerable because, to put it simply, it is not easy to get out of the stirrups and the ability to manoeuvre is greatly reduced.

Comment: Needless to say the non stirrup position (as in NZ) was the preferred option.

Health Services

26-390 Consumer representation: challenges and pitfalls

Piterman HE. Intern Med J. June 2006. Vol.36. No.6. p.378-80.
Reviewed by Dr Helen Moriarty

Review: An Australian article on 'ethics in medicine' which suggests that consumer representation is in fact still a novelty in that country. The author suggests that consumer empowerment in health does not necessarily ensure the patient has a voice, and that political correctness is a major barrier to this. The paper argues that failure to *'question the paradigm of the consumer'* can be detrimental.

Comment: Food for thought. We do not have to agree with all that we read.

Metabolic Diseases

26-391 The metabolic syndrome: is this diagnosis necessary?

Reaven GM. Am J Clin Nutr. June 2006. Vol.83. No.6. p.1237-43.
Reviewed by Dr Charlotte Cox

Review: This and the article by Grundy (see also 26-392) present opposing opinions about the 'fashionable' metabolic syndrome, its relevance and its treatment. The authors are two high profile American heavyweights both having played significant roles in the development of public policy in the prevention of cardiovascular disease. Endocrinologist Dr Gerald Reavan is generally regarded as the main pioneer who linked insulin resistance with the cluster of abnormal variables known to increase cardiovascular risk. He coined this association Syndrome X. It quickly became known as Reaven's Syndrome X and is now termed Metabolic syndrome. In this article, somewhat surprisingly, Reaven argues that the concept of metabolic syndrome has little or no utility in clinical practice. He states his case for providers to now avoid labelling patients with the term metabolic syndrome rather to search for other risk factors in those with existing major CVD risk and aggressively treat each individual risk factor.

26-392 Does a diagnosis of metabolic syndrome have value in clinical practice

Grundy SM. Am J Clin Nutr. June 2006. Vol.83. No.6. p.1248-51.
Reviewed by Dr Charlotte Cox

Review: Grundy opposes the viewpoint expressed by Reaven (see 26-391) and questions whether risk factors for CVD should always be treated individually. One concern about this prescription is that it may lead to the aggressive use of medications at the expense of lifestyle therapies – particularly weight reduction and increased physical activity.
Comment: Very relevant to general practitioners. It is also of interest to be aware of the patch protection being demonstrated by single disorder organisations (such as the American Diabetes Association) versus groups who prefer to focus on risk-factor clustering as a new prevention strategy.

Musculoskeletal System

26-393 Low back pain investigations and prognosis: a review

Refshauge KM, Maher CG. Br J Sports Med. June 2006. Vol.40. No.6. p.494-8.
Reviewed by Dr Chris Milne

Review: Low back pain is very common, and has been extensively studied, but for clinicians, the pathological diagnosis often remains puzzling. Traditional teaching is that nonspecific low back pain is a benign self-limiting condition. However, a large proportion of patients experience persistent low grade pain and disability. Despite this, they are usually able to return to work.
Comment: A very useful review article by an Australian professor of physiotherapy, with 72 references. Challenges some widely held beliefs in a convincing fashion.

26-394 Yoga effective for back pain

J Fam Pract. March 2006. Vol.55. No.3. p.186.
Reviewed by Dr Bruce Adlam

Review: A yoga programme specifically aimed at patients with chronic low back pain is more effective than either exercise treatment or self-care in decreasing functional disability for these patients. The style of yoga is called viniyoga and was adapted for use in patients with low back pain. (Level of evidence =1b RCT [non blinded]) At the end of the 12 weeks of intervention, the disability and bothersome scores in the yoga group were significantly better than either self-care (3.4-point difference) or exercise (1.8-point difference). At 26 weeks, disability and bothersome scores continued to be better in the yoga group. (Original article reviewed: Ann Intern Med 2005; 143: 849-56).

Neurology

26-395 What dietary modifications are indicated for migraines?

Crawford P, Simmons M. J Fam Pract. January 2006. Vol.55. No.1. p.62-6.
Reviewed by Dr Bruce Adlam

Review: Migraine frequency, duration, and severity are not increased by dietary choices (strength of recommendation: A, individual randomised trial [RCT]); they can be decreased by a low-fat diet (SOR: B). Regular supplementation with high-dose riboflavin 400mg/day or magnesium 600mg/day reduces frequency and intensity of migraines (SOR: B, single RCT).
Comment: Contrary to what many of us learned – and to what many patients believe – no food or food additive has been proven to cause migraine headaches; in fact good evidence disproves this notion. The foods once thought to trigger migraines were cheese, alcohol, chocolate and citrus fruit. If you are thinking of upping your marmite intake to get your riboflavin, you would need over 300 tablespoons a day!

Nutrition

26-396 Probiotic use in clinical practice: what are the risks?

Boyle RJ, Robins-Browne RM, Tang MLK. Am J Clin Nutr. June 2006. Vol.83. No.6. p.1256-64.
Reviewed by Dr Charlotte Cox

Review: Probiotics are now widely used in many countries by consumers and in clinical practice. This article reviews the safety of probiotics and cautions use in neonates and those with immune deficiencies.

26-397 Are the eating and exercise habits of successful weight losers changing?

Phelan S, Wyatt HR, Hill JO, et al. Obesity. April 2006. Vol.14. No.4. p.710-6.
Reviewed by Dr Anne-Thea McGill

Review: The objective for this study was to look at changes of large weight losses and maintainers (enrollees had verified >13.6 kg loss for >1 yr, mean 33.1 kg loss maintained for average 5.8 yrs before enrolling).

Participants (N = 2708) were members of the National Weight Control Registry who enrolled in intermittent years. Evaluations of diet and physical activity were conducted at entry into the NWCR and prospectively over one year. From 1995 to 2003, the daily percentage of calories from fat increased from 23.8% to 29.4%, saturated fat intake increased from 12.3 to 15.0 g/d, and calories from carbohydrate decreased from 56.0% to 49.3% ($p < 0.0001$). The proportion consuming <90 grams of carbohydrate (considered a 'low-carb' diet) increased from 5.9% TO 17.1% ($p = 0.0001$) (still a minority). Physical activity was elevated in 1995 (mean = 3316 kcal/wk) but comparable in all other years (mean = 2620 kcal/wk).

Comment: Studying this unusual group is important in that they maintain weight loss for long periods. Despite changes in the diet (due to the 'low-carb' fashion) over eight years these cohorts retained the same variables associated with long-term maintenance of weight loss: continued consumption of a low-calorie diet with low-moderated fat intake, high vegetable and fruit intake – although this aspect was minimised in the article – limited fast food, and high levels of physical activity.

26-398 Omega-3 fats do not affect mortality rates

Shaughnessy AF. Am Fam Physician. 1 August 2006. Vol.74. No.3. p.489-91.
Reviewed by Dr Andrea Steinberg

Review: Clinical Question: Does supplementation with omega-3 fatty acids decrease mortality, cardiovascular disease, or cancer in adults? Study Design: Systematic review. Synopsis: In this update of a previous Cochrane review the authors identified 48 randomised controlled trials and 41 cohort studies evaluating the effect of fish oil supplementation on overall mortality, cardiovascular disease, and cancer in adults. Bottom Line: Overall, omega-3 fatty acid supplementation does not decrease mortality or cardiovascular disease compared with placebo. This study combined primary and secondary prevention; that is, it included persons with or without coronary heart disease. (Level of Evidence: 1a) (Original article reviewed: BMJ Apr 1, 2006;332: 752-60).

Oncology

26-399 Metastatic breast cancer

Stevanovic A, Lee P, Wilcken N. Aust Fam Physician. May 2006. Vol.35. No.5. p.309-12.
Reviewed by Dr Mary Tucker

Review: This fourteenth article in the series on breast disease gives an overview of what to look for in the patient with a past history of early breast cancer and how to assess and support the patient with metastatic breast cancer in the general practice setting. Investigation of the symptoms of possible metastatic disease is discussed and options are presented in tabular form. Treatment options are discussed and problems requiring urgent intervention are highlighted. The aim of treatment is to maximise quality and quantity of life while accepting that there is no realistic prospect of cure. Information about the latest medical oncology treatments, including new chemotherapies and targeted 'biological' therapies is provided.

Comment: This review recognises the important role of the GP in the early diagnosis of metastatic breast cancer and the provision of ongoing care and support.

26-400 Family history in colorectal cancer surveillance strategies

Hakama M. Lancet. 8-14 July 2006. Vol.368. No.9530. p.101-3.
Reviewed by Dr Tony Hanne

Review: Should screening for colorectal cancer be based primarily on a positive family history? This Finnish epidemiologist questions what has become accepted wisdom that family history is the key. Because this cancer is common in European populations it is important to know how much of the 4% lifetime risk of developing this cancer is related to family history. The answer is only about 14%, which means that the remaining 86% would not be detected early in such a targeted screening programme.

Comment: We cannot escape the constraints of limited resources, which mean that many referrals for colonoscopy in the public system are either denied or too long delayed. At the same time we need a high index of suspicion even when there is no family history. The intention to introduce occult blood testing as a national screening programme is welcome as a way of making that suspicion better informed.

26-401 Stem cells: the real culprits in cancer?

Clarke MF, Becker MW. Sci Am. July 2006. Vol.295. No.1. p.34-41.
Reviewed by Dr Ron Vautier

Review: In many types of cancer only a small subset of tumour cells have the ability to proliferate and expand the disease. Such cells have similar properties to normal stem cells including an unlimited lifespan and the ability to generate a diverse range of other cell types. They evidently arise from regulatory failures in damaged stem cells or their immediate offspring.

Comment: This article can certainly be recommended to those who are particularly interested in understanding the fundamental biology of medicine, but is not of any immediate practical application.

26-402 Risk in primary care of colorectal cancer from new onset rectal bleeding: 10 year prospective study

du Toit J, Hamilton W, Barraclough K. BMJ. 8 July 2006. Vol.333. No.7558. p.69-70.
Reviewed by Dr Len Brake

Review: The objective of this study was to measure the risk of colorectal cancer and adenoma with new onset rectal bleeding. Over a 10 year period 265 patients were included and 1 in 10 of these had colonic neoplasia. This apparently included all cases

of rectal bleeding irrespective of possible anal causes. The investigations were sigmoidoscopy, barium enema or colonoscopy. (Commentary attached).
Comment: The point the authors make is that change of bowel habit does not have to be a symptom as well as bleeding.

Orthopaedics

26-403 Vertebroplasty: a new treatment for vertebral compression fractures

Guduguntla M, Subramaniam R. Aust Fam Physician. May 2006. Vol.35. No.5. p.304-7.
Reviewed by Dr Mary Tucker
Review: Vertebroplasty has gained popularity since 1987 for treatment of severe pain unresponsive to analgesia due to vertebral compression fractures of osteoporotic or malignant origin. It involves the injection, using imaging guidance, of artificial bone cement and an opacifier into the inter-trabecular marrow space of the fractured vertebra under conscious sedation and using local anaesthetic. The injected bone cement acts as an internal splint to reinforce and stabilise the fracture thus alleviating pain. Major complications occur in less than 1% of osteoporotic patients and in 5% of those treated for compression fractures related to malignancy.
Comment: Vertebroplasty appears to be a safe, effective, and cost-effective procedure when performed by adequately trained interventional radiologists.

Palliative Treatment

26-404 Experience of dying: concerns of dying patients and of carers

Terry W, Olson LG, Wilss L, et al. Intern Med J. June 2006. Vol.36. No.6. p.338-46.
Reviewed by Dr Helen Moriarty
Review: This paper describes the findings from interviews of 36 patients of a NSW palliative care service. The qualitative methodology is nicely summarised. Findings were categorised into topics of (1) privacy and autonomy, unauthorised disclosures, control over decisions and emotional privacy; (2) getting information about dying, medication, etc.; (3) practical and emotional support and desire to shorten life.
Comment: Although suicide and euthanasia were specifically avoided as interview topics, shortening life emerged as a theme. Concerns about morality of suicide also emerged.

Paediatrics

26-405 Chronic musculoskeletal pain in children: Part I. Initial evaluation

Junnila JL, Cartwright VW. Am Fam Physician. 1 July 2006. Vol.74. No.1. p.115-24.
Reviewed by Dr Andrea Steinberg
Review: Musculoskeletal pain during childhood is common; in population surveys, ~16 percent of school-age children reported limb pain. This article, Part I of the series, presents a logical and comprehensive clinical approach to the child with musculoskeletal pain. It recommends thorough clinical assessment and judicious use of investigations, without which, the term 'growing pains' may be applied mistakenly to children who have a serious rheumatic or malignant disease. (See 26-406)

26-406 Chronic musculoskeletal pain in children: Part II. Rheumatic causes

Junnila JL, Cartwright VW. Am Fam Physician. 15 July 2006. Vol.74. No.2. p.292-302.
Reviewed by Dr Andrea Steinberg
Review: This article, Part II of the series, addresses initial diagnosis and treatment of rheumatic disease and discusses the most common specific rheumatic conditions of childhood that manifest as musculoskeletal pain. These include acute rheumatic fever or streptococcal infection-related arthritis, benign hypermobility syndrome, benign nocturnal limb pains of childhood ('growing pains'), Henoch-Schönlein purpura, juvenile rheumatoid arthritis and other less common conditions such as SLE, malignancy, ankylosing spondylitis, Reiters, psoriatic arthopathy etc. (See 26-405)

Pharmacology

26-407 Which patients taking SSRIs are at greatest risk of bleeding?

Mansour A, Pearce M, Johnson B, et al. J Fam Pract. March 2006. Vol.55. No.3. p.206-8.
Reviewed by Dr Bruce Adlam
Review: Patients taking selective serotonin reuptake inhibitors (SSRIs) seem to be at higher risk of bleeding episodes than those taking non-SSRI antidepressants. A large (N=26,005) cohort study of all users of antidepressants in a Danish county found that the risk of upper GI bleeding was higher with SSRIs compared with non-SSRIs and other antidepressants. Concomitant use of aspirin and NSAIDs further increased the risk by 12.2 and 5.2 times, respectively. The risk apparently depends on degree of SSRI selectivity and concomitant use of other agents.
Comment: This review came up with the following recommendations: (1) For patients at high risk of abnormal bleeding, consider prescribing an antidepressant with low serotonin reuptake inhibition, which may lower risk; (2) For patients taking high serotonin reuptake inhibition antidepressants, recommend avoidance or minimal use of nonsteroidal anti-inflammatory drugs and aspirin.

Practice Management

26-408 Effect of enhanced feedback and brief educational reminder messages on laboratory test requesting in primary care: a cluster randomised trial

Thomas RE, Croal BL, Ramsay C, et al. Lancet. 17-23 June 2006. Vol.367. No.9527. p.1990-6.
Reviewed by Dr Tony Hanne

Review: A Scottish hospital-based laboratory gave feedback to some practices but not others on levels of certain tests such as FSH, TSH and ferritin which it was thought were being overused for non-specific investigations. They also added educational messages about the limited value of these tests in vague illness to reports for some practices. Both strategies had the effect, roughly equally, of reducing the levels of tests requested. When each intervention was stopped, the effect gradually wore off.
Comment: We have been accustomed for several years in New Zealand to such strategies to reduce waste of laboratory budgets. We have also had experience of budget holding where there is a financial incentive for practices to test less. We are just currently beginning a new wave of Performance Management targets, which include laboratory tests. We know these approaches save money. What we do not know, and probably the Scots also do not know, is when such pressure begins to discourage some doctors from doing some important tests on some patients.

Prescribing

26–409 Cephalosporins can be prescribed safely for penicillin-allergic patients

Pichichero ME. J Fam Pract. February 2006. Vol.55. No.2. p.106-12.
Reviewed by Dr Bruce Adlam
Review: According to this review the widely quoted cross-allergy risk of 10% between penicillin and cephalosporins is a myth. First generation cephalosporins (cephalothin, cephalexin, cefadroxil, and cefazolin) confer an increased risk of allergic reaction among patients with penicillin allergy, but second and third generation cephalosporins (cefprozil, cefuroxime, cefpodoxime, ceftazidime, and ceftriaxone) do not increase risk of an allergic reaction. (Strength of recommendation B.)

Preventive Medicine and Screening

26–410 FOBT in healthy patients does not reduce mortality

Ebell M. Am Fam Physician. 15 July 2006. Vol.74. No.2. p.325-6.
Reviewed by Dr Andrea Steinberg
Review: Clinical Question: Does faecal occult blood testing (FOBT) reduce all-cause mortality? Setting: Population-based. Study Design: Meta- analysis (randomised controlled trials). Synopsis: This study tried to determine if FOBT reduces all-cause mortality. The authors combined data from three large published randomised trials of FOBT: one Danish, one British, and one American. All studies compared FOBT, performed every two years, with no screening. There was a 1.9 per cent relative increase in noncolorectal cancer deaths in the nonscreened group, and no overall difference between groups in all-cause mortality (26.51 for screened and 26.46 for nonscreened patients). Bottom Line: Screening for colorectal cancer using FOBT does not reduce all-cause mortality. This is important when considering whether to screen healthy patients. (Level of Evidence: 1a) (Original article reviewed: Am J Gastroenterol Feb 2006;101: 380-4).
Comment: Potential explanations for this interesting paradox include unintended consequences of screening (e.g. failure of the patient to adopt a healthier lifestyle because he or she has been screened, mortality from follow-up colonoscopy) and better identification of colorectal cancer as a cause of death in screened patients.

Psychiatry and Psychology

26–411 Long-term follow-up of people with co- existing psychiatric and substance use disorders: patterns of use and outcomes

Greig, RL, Baker A, Lewin TJ, et al. Drug Alcohol Rev. May 2006. Vol.25. No.3. p.249-58.
Reviewed by Dr Helen Moriarty
Review: This paper used opportunistic four to six year follow-up of patients from a previous study, using that data of six and 12 month changes from baseline. As expected persistent hazardous drug use was predictive of more social and psychiatric adverse outcomes. Intermittent and non hazardous use was associated with fewer adverse outcomes. Ten per cent male mortality was an unexpected finding.
Comment: Studies of this kind are few and far between. One major problem is the sample size for subgroup analysis, given the wide variety of substances and patterns of use.

26–412 Reforming youth mental health

McGorry P. Aust Fam Physician. May 2006. Vol.35. No.5. p.314.
Reviewed by Dr Mary Tucker
Review: Across the lifespan, young people aged 12–25 years face the greatest risk of the onset of potentially serious mental and substance abuse disorders, with a peak prevalence between 18 and 25 years of one in four in a 12 month period. Psychotic disorders for a small subset have the potential to cause severe disability and psychosocial damage and even death. The challenge of early diagnosis and the importance of new models of care are discussed.
Comment: Setting the scene for the articles in this issue of the *Australian Family Physician* on the theme of the recognition and management of early psychosis.

26–413 Emerging psychosis in young people – Part 1: key issues for detection and assessment

Berger G, Fraser R, Carbone S, et al. Aust Fam Physician. May 2006. Vol.35. No.5. p.315-21.
Reviewed by Dr Mary Tucker
Review: Early diagnosis and treatment has the potential to alter the course of psychotic illness in young people and prevent psychological distress, social decline and lasting brain changes. General practitioners are ideally placed to be aware of risk

factors, (FH of psychotic illness, decline in functioning and a brief, self limiting psychotic episode – even if drug related), and to identify the early warning signs of emerging psychotic illnesses, (behavioural, emotional and cognitive disturbances), and make prompt referral to specialist mental health services. Screening and assessment, including assessment of suicide risk, are explored and an action plan for investigation, follow-up and referral is outlined.

Comment: Excellent guidelines for the early diagnosis and treatment of a potentially destructive problem. The crucial role of general practitioners in identifying emerging psychoses and initiating appropriate treatment is highlighted.

26–414 Emerging psychosis in young people – Part 2: key issues for acute management

Fraser R, Berger G, McGorry P. Aust Fam Physician. May 2006. Vol.35. No.5. p.323-7.

Reviewed by Dr Mary Tucker

Review: Close collaboration between the general practitioner and a multidisciplinary mental health team is desirable once an emerging psychotic disorder is confirmed, but the GP may need to initiate antipsychotic medication in order to avoid delay in commencing therapy. The engagement of the young person, and ideally their family, carers and friends, into a long-term therapeutic alliance is of vital importance as failure to adhere to therapy carries an 80% risk of relapse within five years, with associated impairment of cognitive function. Atypical antipsychotics are more effective and better tolerated than conventional antipsychotics and produce a better long-term outcome. The choice of antipsychotic is explored and the importance of treatment of comorbidities is discussed.

Comment: The importance of a long-term therapeutic alliance between GP and patient is highlighted and clear guidelines with regard to management are offered.

26–415 Emerging psychosis in young people – Part 3: key issues for prolonged recovery

Fraser R, Berger G, Killackey E, et al. Aust Fam Physician. May 2006. Vol.35. No.5. p.329-32.

Reviewed by Dr Mary Tucker

Review: While 80% of psychotic patients will achieve symptomatic recovery after one year of treatment, only 50% will achieve full functional recovery, and about 10–20% will have treatment refractory symptoms and this figure rises to 30–50% over the lifetime of the patient. This article attempts to provide strategies to prevent long-term disability in this vulnerable population. The prevention of relapse and the psychosocial development of the individual are key in fostering and promoting a healthy lifestyle, leading to improved quality of life. Treatment refractory patients need specialist care.

Comment: The role of the GP in providing regular long-term support and supervision of therapy remains pivotal to ensuring an optimal outcome for this group of patients.

26–416 Suicide prevention: targeting the patient at risk

Bridge S. Aust Fam Physician. May 2006. Vol.35. No.5. p.335-8.

Reviewed by Dr Mary Tucker

Review: Suicide is the commonest cause of death between the ages of 25 and 55 years and is the second commonest cause of death in adolescents. Risk factors for suicide are identified and impulsivity is highlighted. Research into the role of impulsivity in suicide would suggest that unless the patient has strategies to confront the suicidal thoughts themselves, they remain at significant risk. Strategies for dealing with suicidal thoughts are discussed and a link is provided to *'Toughin' it out – Survival skills for dealing with suicidal thoughts.'*

Comment: A practical discussion of suicide and its prevention. This article provides education on an important topic and offers practical strategies for suicide prevention. *'Toughin' it out – Survival skills for dealing with suicidal thoughts'* is available for download at www.toughinitout.com and should prove to be a valuable resource, which can be offered to patients who are thought to be at risk of suicide.

26–417 How have the SSRI antidepressants affected suicide risk?

Hall WD. Lancet. 17-22 June 2006. Vol.367. No.9527. p.1959-62.

Reviewed by Dr Tony Hanne

Review: The messages on this question have been confusing. Some studies have suggested that SSRIs have an increased risk of suicide though they are agreed to be more effective than older antidepressants and more acceptable because of lower side effects. Other research reports a lower risk. Some find a higher risk in adolescents but not in the rest of the population. Other investigators only find a higher risk in those over 65. The cautious conclusion of this review of meta-analyses and observational studies suggests that if there is increased suicide risk it is in the first two weeks of treatment when psychomotor retardation has lifted but mood has not yet improved.

Comment: The suggestion is also made that those who admit to suicidal ideation may be those in whom SSRIs are more likely to be used. What is clear from this article is the importance of a close relationship with depressed patients particularly in the early days of treatment from doctors, family and friends, all of whom need to be aware of risk. (For editorial comment see 26-418).

26–418 Clinical trials in children, for children

Lancet. 17-23 June 2006. Vol.367. No.9527. p.1953.

Reviewed by Dr Tony Hanne

Review: See 26-417.

26–419 Antidepressant discontinuation syndrome

Warner CH, Bobo W, Warner C, et al. Am Fam Physician. 1 August 2006. Vol.74. No.3. p.449-56.
Reviewed by Dr Andrea Steinberg
Review: Antidepressant discontinuation syndrome occurs in approximately 20 per cent of patients after abrupt discontinuation of an antidepressant medication (SSRI, MAOIs, TACs, and atypical agents e.g. venlafaxine) that was taken for at least six weeks. Typical symptoms of antidepressant discontinuation syndrome occur usually within three days, and include flu-like symptoms, insomnia, nausea, imbalance, sensory disturbances, and hyperarousal. These symptoms usually are mild, last one to two weeks, and are rapidly extinguished with reinstitution of antidepressant medication. Antidepressant discontinuation syndrome is more likely with a longer duration of treatment and a shorter half-life of the treatment drug. The importance of this syndrome is threefold: (1) though typically mild, antidepressant discontinuation syndrome symptoms are associated with significant discomfort, work absenteeism, other psychosocial problems, and may on rare occasions be severe enough to require hospitalisation; (2) failure to recognise antidepressant discontinuation syndrome may result in medical and psychiatric misdiagnosis; (3) patients may be unwilling to use psychotropic medications in the future. Patients should be forewarned of the possibility of antidepressant discontinuation syndrome if antidepressants are discontinued, and that supervised tapering of medication over six to eight weeks may be required to minimise discontinuation symptoms. Several RCTs have shown that with abrupt cessation of antidepressants, symptoms can begin within days. There are no clear, validated tapering recommendations.
Comment: Something to consider in a patient receiving antidepressant medication who suddenly deteriorates clinically – have they self-discontinued their medication? (Patient information sheet attached).

26–420 Regular exercise reduces dementia risk

Lin KW. Am Fam Physician. 1 August 2006. Vol.74. No.3. p.491-2.
Reviewed by Dr Andrea Steinberg
Review: This was a prospective cohort study to examine the relationship between regular exercise and the onset of dementia in adults 65 years and older, in a group of 1740 participants who scored above the 25th percentile on a screening test for cognitive function and did not have a previous dementia diagnosis. Mean follow-up was 6.2 years. Participants who exercised regularly were significantly less likely to develop dementia than those who did not, with an adjusted risk ratio of 0.62 (95% confidence interval, 0.44 to 0.86). The difference in incidence of dementia between the two groups also was striking: 13.0 per 1000 in the regular exercise group and 19.7 per 1000 in the group who exercised less often. Regular exercise produced the greatest dementia risk reduction in participants with the poorest physical function scores at baseline. (Original article reviewed: Ann Intern Med Jan 17, 2006; 144: 73-81).

Public Health

26–421 Disaster medical response: maximizing your effectiveness

Campos-Outcalt D. J Fam Pract. February 2006. Vol.55. No.2. p.113-5.
Reviewed by Dr Bruce Adlam
Review: In the aftermath of Hurricane Katrina, physicians and other health professionals volunteered for deployment to the affected area to provide medical services. The frustrating reality most of them encountered was the incapacity of those in charge to use the number of professional volunteers expressing interest.
Comment: Quite a good article for those PHOs interested in emergency preparedness planning as it's all about infrastructure, first things first (water, sanitation, shelter and immunisations) and identifying those things that can wait, such as burial (contrary to common belief). A better resource is the various WHO guidelines for the specific disasters more likely to occur in NZ (e.g. earthquake, flooding, etc.)

Radiology

26–422 Use of diagnostic imaging in Australian general practice

Miller G, Valenti L, Charles J. Aust Fam Physician. May 2006. Vol.35. No.5. p.280-1.
Reviewed by Dr Mary Tucker
Review: This article provides an overview of diagnostic imaging ordered by Australian general practitioners. Use of diagnostic imaging has increased over the last 10 years. Selection of imaging techniques by GPs is generally appropriate with the exception of the use of CT scanning for the investigation of back complaints when MRI would be more appropriate. MRI usage is limited by cost and problems with access to the service.
Comment: Setting the scene for the articles in this issue of *Australian Family Physician* on the theme of diagnostic imaging.

26–423 Radiological tests in investigations of atypical chest pain

Kupershmidt M, Varma D. Aust Fam Physician. May 2006. Vol.35. No.5. p.282-7.
Reviewed by Dr Mary Tucker
Review: While a thorough history and careful physical examination is paramount, diagnostic imaging is indispensable in patients presenting with atypical chest pain (ACP). The causes of ACP, (pain not typical of MI), and appropriate radiological investigations are tabulated for ease of reference and are subsequently discussed in greater detail. The article is well illustrated and important issues are highlighted.
Comment: A useful review and update on clinically relevant investigations.

26–424 Myocardial perfusion imaging: A validated and mature cardiac imaging modality

Pitman A. Aust Fam Physician. May 2006. Vol.35. No.5. p.288-92.

Reviewed by Dr Mary Tucker

Review: An update on the use of nuclear Myocardial Perfusion Imaging (MPI) for the triaging of chest pain, monitoring of known ischaemic heart disease, and cardiac event prediction in the general practice setting. Tracer uptake by the myocardium directly reflects the adequacy of myocardial perfusion. A normal stress MPI study is an unambiguous outcome and carries a risk of cardiac events of less than 1% pa. Left ventricular ejection fraction is routinely reported and offers survival information. Nuclear MPI effectively identifies significant myocardial ischaemia and predicts cardiac outcome, monitors known ischaemic heart disease (IHD), documenting exercise performance, severity and progression of ischaemia and non-recurrence of treated IHD. In patients without chest pain, nuclear MPI provides an accurate cardiac prognosis.

Comment: Nuclear MPI is a well validated, safe and practically useful imaging modality deserving of wider use in general practice. Specialist referral is required in New Zealand for Medical Insurance coverage

26–425 What's new in vascular interventional radiology? Aortic stent grafting

Leaney B. Aust Fam Physician. May 2006. Vol.35. No.5. p.294-7.

Reviewed by Dr Mary Tucker

Review: The use of stenting to restore the lumen of arteries of various sizes is reviewed. Percutaneous intraluminal aortic stent grafts have been inserted with increasing frequency since the 1990s. The procedure carries less risk to the patient, is associated with less morbidity and mortality than traditional surgical procedures, and results in earlier discharge. The self-expanding grafts, (Dacron tubes with multiple, self-expanding radial metal stents), are supplied within a small caliber, withdrawable sheath. Accurate pre-operative assessment with a high quality CT angiogram combined with correct graft selection is vital for the success of the procedure, which should be performed at a site with relevant expertise that maintains good liaison with the vascular surgery team.

Comment: The non-invasive nature of the procedure often allows patients to be discharged 48–72 hours after the procedure – a major advantage when compared with traditional treatment.

Respiratory System

26–426 What are hospital admission criteria for infants with bronchiolitis?

Lind I, Gill JH, Calabretta N. J Fam Pract. January 2006. Vol.55. No.1. p.67-9.

Reviewed by Dr Bruce Adlam

Review: If you are looking for something to hang your hat on this article won't help much. The conclusion is that clinical judgment remains the gold standard for hospital admission of infants with bronchiolitis, and it cannot be replaced by objective criteria (strength of recommendation = B). Oxygen saturation (SaO2) is the most consistent clinical predictor of deterioration, though different investigators vary cutoffs from 90% to 95% SaO2 and the vast majority of infants with saturations in this range do well. A table of risk factors for deterioration in infants with bronchiolitis at the initial presentation risk factors is included: (1) Tachypnea (respiratory rate >60-80) or retractions (2) Hypoxia: cutoffs ranging from SaO2 <90% to <95% (3) Difficulty feeding or dehydration (4) Age <12 months (the lower the age, the higher the risk) (5) Comorbidities (6) Prematurity Gestational age at birth <36 weeks (7) Lower socioeconomic groups.

Comment: The key is being able to identify a 'sick' child.

26–427 Comparison of Australian and international guidelines for grading severity of chronic obstructive pulmonary disease

Kyoong A, Mol S, Guy P, et al. Intern Med J. August 2006. Vol.36. No.8. p.506-512.

Reviewed by Dr Helen Moriarty

Review: A paper which challenges the movement toward use of clinical guidelines. Sixty-one Melbourne COPD outpatients had been assessed against international guidelines for measuring disease severity, GOLD, and Australian guidelines COPD-X. These rated some patients very differently. In one system those classified with 'mild' disease rated as having 'no' disease in the other, similarly there were overlaps in all other categories including 'severe'.

Comment: Prognosis and management plans depend upon an assessment of severity. The discrepancies highlight a fundamental guideline problem.

26–428 Effectiveness of discontinuing antibiotic treatment after three days versus eight days in mild to moderate-severe community acquired pneumonia: randomised, double blind study

el Moussaoui R, de Borgie CA, van den Broek P, et al. BMJ. 10 June 2006. Vol.332. No.7554. p.1355-?

Reviewed by Dr Len Brake

Review: This study confirms that a three day course of amoxicillin is as effective as the standard longer course in this disorder. A shorter duration of treatment can help contain the growing resistance rates among respiratory pathogens.

Comment: It shows that 'the rules' are in fact often arbitrary. For example, there was a time when a single IM shot of antibiotic was a common and effective treatment for throat infections in children – so a good reason had to be made by the GP to the parent that the child needed an injection. With the introduction of the flavoured sugar medicines the tables have turned with parents often doctor chasing until

an antibiotic is prescribed whether it is indicated or not.

Rheumatic Diseases

26–429 NSAIDs in osteoarthritis: irreplaceable or troublesome guidelines?

Bjordal J. Br J Sports Med. April 2006. Vol.40. No.4. p.285-6.
Reviewed by Dr Chris Milne

Review: Half of the eight million patients with osteoarthritis in the UK use NSAIDs regularly, and this contributes to an estimated 2000 deaths annually from side effects in that country. Recent concerns re the safety of COXIBs have added to the confusion.
Comment: The real answer is to focus on the non pharmacological treatments such as appropriate footwear (with viscoelastic inserts if needed) and quadriceps strengthening plus weight loss. This is advocated in the commentary to this article.

26–430 Glucosamine plus chondroitin for osteoarthritis

Ebell M. Am Fam Physician. 1 July 2006. Vol.74. No.1. p.158, 161.
Reviewed by Dr Andrea Steinberg

Review: Clinical Question: Is glucosamine or chondroitin (or both) effective for osteoarthritis of the knee? Setting: Outpatient (any). Study Design: Randomised controlled trial (double-blinded). Synopsis: A previous meta-analysis of glucosamine and chondroitin for osteoarthritis found a consistent benefit from treatment and good safety (McAlindon TE, et al. Glucosamine and chondroitin for treatment of osteoarthritis: a systematic quality assessment and meta- analysis. JAMA 2000;283:1469-75). However, many of the studies were small, did not report allocation concealment, were sponsored or conducted by drug manufacturers, or had other limitations that could lead to bias. In this study, 1583 patients with clinical and radiographic evidence of osteoarthritis of the knee were randomised (allocation concealed) to one of five groups: placebo; glucosamine hydrochloride 500 mg three times daily; chondroitin 400 mg three times daily; glucosamine hydrochloride 500 mg plus chondroitin 400 mg three times daily; or celecoxib (Celebrex) 200 mg once daily. Results showed an 85 per cent probability of identifying a clinically significant 15 per cent improvement difference between active treatment and placebo groups. Bottom Line: Glucosamine hydrochloride plus chondroitin provides modest symptomatic benefit for patients with mild osteoarthritis of the knee. In addition, post hoc analysis suggests a large benefit in patients with moderate to severe pain. (Level of Evidence: 1b) (Original article reviewed: N Engl J Med Feb 23, 2006;354: 795-808).

Screening

26–431 What is the best surveillance for hepatocellular carcinoma in chronic carriers of hepatitis B?

Rugge JB, Lochner J, Judkins D. J Fam Pract. February 2006. Vol.55. No.2. p.155-6.
Reviewed by Dr Bruce Adlam

Review: Screening patients with chronic hepatitis B infection (HBsAg+) for hepatocellular carcinoma by alpha-fetoprotein (AFP) or by AFP plus ultrasound will detect hepatocellular carcinoma tumors at earlier stages and increases resection rates. (Strength of recommendation B, based on a systematic review of RCTs).
Comment: It is unclear whether screening with AFP or AFP/US actually improves disease-specific or all-cause mortality.

Smoking

26–432 Interventions to facilitate smoking cessation

Okuyemi KS, Nollen NL, Ahluwalia JS. Am Fam Physician. 15 July 2006. Vol.74. No.2. p.262-75.
Reviewed by Dr Andrea Steinberg

Review: Smoking cessation significantly reduces morbidity and mortality from smoking. This article provides a comprehensive summary of the evidence for success of different forms of intervention as well as the varieties and quit rates of nicotine replacement therapy.
Comment: Don't forget to always ask about smoking status! Smoking cessation is among the most cost-effective measures in primary care. Even a brief intervention (i.e. couple of minutes of advice) can lead to a quit rate of 2–10% at six months. (Patient information sheet attached).

Sports and Sports Medicine

26–433 Epidemiology of injuries and illnesses in America's Cup yacht racing

Neville VJ, Molloy J, Brooks, JH, et al. Br J Sports Med. April 2006. Vol.40. No.4. p.304-12.
Reviewed by Dr Chris Milne

Review: This article documents the injuries and illnesses to the Prada crew in the 2003 America's Cup challenge. Upper limb injuries predominated – these included tendiopathies including rotator cuff and tennis elbow, and entrapment of the posterior interosseus nerve – this presents like a variant of tennis elbow, especially in grinders.
Comment: This excellent paper details the injuries and illnesses sustained by a professional sailing team in a very detailed fashion. Dale Speedy of The University of Auckland, Department of General Practice and Primary Health Care should be congratulated on its presentation.

26–434 Sports injuries: population based representative data on incidence, diagnosis, sequelae, and high risk groups

Schneider S, Seither B, Tonges S, et al. Br J Sports Med. April 2006. Vol.40. No.4. p.334-9.
Reviewed by Dr Chris Milne

Review: This is a report on a nationwide study in Germany. It documented the incidence, type, site and extent of sports injuries, and their implications in terms of occupational disability and time off work. Not surprisingly, young men present the main high risk group, as in New Zealand.
Comment: This study shows the impact of sports injuries in a large western democracy, and is of interest to clinicians, epidemiologists and probably also to ACC.

26–435 Use of Beta2 agonists in sport: are the present criteria right?

Orellana JN, Prada RA, Marquez MD. Br J Sports Med. April 2006. Vol.40. No.4. p.363-6.
Reviewed by Dr Chris Milne
Review: In answer to the question – no, in the opinion of these authors. B2 agonist use by athletes has become progressively more restricted, and at Olympic level is limited to those with a fall in FEV1 with challenge of methacholine at 2mg/ml, and reversal with bronchodilators. This probably excludes about 30% of those with asthma.
Comment: I agree with these authors, and think that a large number of athletes at being denied effective treatment simply because high dose oral B2 agonists are known to enhance performance and the authorities wanted a scientific test they could use to be seen to 'get tough'. It is not acceptable for bronchial obstruction criteria to be different if the patient is an athlete.

26–436 Applied physiology of tennis performance

Kovacs MS. Br J Sports Med. May 2006. Vol.40. No.5. p.381-6.
Reviewed by Dr Chris Milne
Review: As the author states, tennis is a sport based on unpredictability – of point, length, shot selection, strategy, match duration, weather and the opponent. Tennis players should train in a specific manner to improve tennis – specific performance and reduce injury.
Comment: A very good primer on the physiology of tennis. Sixty-four references.

26–437 Unforced errors and error reduction in tennis

Brody H. Br J Sports Med. May 2006. Vol.40. No.5. p.397-400.
Reviewed by Dr Chris Milne
Review: This article focuses on three areas – reduction of lateral errors and errors of depth, increasing the chances of hitting the serve into the service box, and finally on the 'sweet spots' – where exactly on the racquet head the player should hit the ball for various shots.
Comment: If you're a recreational player, or advising players at any level, this article has some great tips and advice.

26–438 Modern tennis rackets, balls, and surfaces

Miller S. Br J Sports Med. May 2006. Vol.40. No.5. p.401-5.
Reviewed by Dr Chris Milne
Review: Modern rackets are stiffer than their wooden predecessors. They have transformed the game to one characterised by power and spin. Tennis balls have become harder, which probably contributes to tennis elbow.
Comment: As for other sports, tennis has been transformed by technology, and the use of new materials for playing equipment. You can argue the merits or otherwise of this, but you won't find a better easy-to-digest article about this topic.

26–439 Tennis injuries: occurrence, aetiology, and prevention

Pluim BM, Staal JB, Windler GE, et al. Br J Sports Med. May 2006. Vol.40. No.5. p.415-23.
Reviewed by Dr Chris Milne
Review: This review article considers studies from 1966 to the present. Surprisingly, most tennis injuries occur in the lower extremities, and there is a great variation in the reported incidence of the various injuries. As yet, there are no randomised controlled trials investigating injury prevention measures in tennis.
Comment: Very comprehensive article by Babette Pluim who is one of the leading authorities on tennis injures. One hundred and fory-eight references.

26–440 Shoulder injuries in tennis players

van der Hoeven H, Kibler WB. Br J Sports Med. May 2006. Vol.40. No.5. p.435-40.
Reviewed by Dr Chris Milne
Review: This article describes the principle of the kinetic chain (i.e. the energy for a tennis shot is generated by a series of muscles from the ground up). It also describes the contributors to overuse injury to the rotator cuff and shoulder capsule.
Comment: Written by Ben Kibler, one of the world authorities on shoulder injuries, this article describes principles that can be applied to other racket and throwing sports.

26–441 Health benefits for veteran (senior) tennis players

Marks BL. Br J Sports Med. May 2006. Vol.40. No.5. p.469-76.
Reviewed by Dr Chris Milne
Review: The health of veteran tennis players is characterised by enhanced aerobic capacity, increased bone density in specific regions, lower body fat, and maintained reaction time in comparison with age matched but less active controls.
Comment: This article exemplifies the health benefits of an active lifestyle. Unlike some sports, tennis can be enjoyed safely through the lifespan.

26–442 Regulation of reproductive function in athletic women: an investigation of the roles of energy availability and body composition

Zanker CL. Br J Sports Med. June 2006. Vol.40. No.6. p.489-90.
Reviewed by Dr Chris Milne
Review: Exercise associated reproduction dysfunction is mainly caused by

deficits of readily available energy. The reproductive system is extremely sensitive to nutritional restriction. Leptin acts on the hypothalamus, and if the leptin level drops below a critical threshold, the hypothalamic GnRH pulse switches off.

Comment: This article by Cathy Zanker, one of the world experts on this condition, is well worth reading by those with an interest in this field.

26–443 Clinical utility of blood tests in elite athletes with short term fatigue

Fallon KE. Br J Sports Med. June 2006. Vol.40. No.6. p.541-4.

Reviewed by Dr Chris Milne

Review: A sequential series of 50 elite athletes presenting with a primary complaint of fatigue or tiredness were investigated at the Australian Institute of Sport. In only one case (2%) did the results of routine blood tests lead to an alteration in diagnosis. Physical examination did not provide any findings that would not have been suspected from the history, except for a number of irrelevant incidental findings.

Comment: It's just as our early clinical teachers told us – the history is the cornerstone of medical diagnosis, even for this perplexing, difficult to evaluate problem.

Therapeutics

26–444 Lidocaine patch 5% for carpal tunnel syndrome: How it compares with injections: a pilot study

Nalamachu S, Crockett RS, Mathur D. J Fam Pract. March 2006. Vol.55. No.3. p.209-14.

Reviewed by Dr Bruce Adlam

Review: The lidocaine patch 5% provided pain relief for mild-to-moderate carpal tunnel syndrome and may offer patients a non-invasive treatment option with minimal risk for drug-drug interactions or systemic side effects.

Comment: Lidocaine patches are available in NZ. This was a pharmaceutical company sponsored study.

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Advertising enquiries:

Colin Gestro ph: 09–419 6723, fax: 09–419 6790, email: colingestro@affinityads.com

All other correspondence to:

Lee Sheppard, Publications Administrator
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