Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Acupunct Med*
BMJ*
Br J Sports Med*
Can Fam Physician Med Fam Can*
Drug Alcohol Rev*
Intern Med J*
J Fam Pract*
Lancet*
N Engl J Med*
Obesity*
Palliative Med*
Pediatrics*
Prim Care*
Sci Am*

* Journals indexed in Medline

Acupuncture

27–350 Effects of trigger point acupuncture on chronic low back pain in elderly patients – a sham-controlled randomised trial

Itoh K, Katsumi Y, Hirota S, et al. Acupunct Med. 2006. Vol.24. No.1. p.5-12.

Reviewed by Dr Alex Chan

Review: In this trial, patients with low back pain for more than six months duration were randomised to trigger points acupuncture (group A) and sham acupuncture (group B) in a patient- and assessor-blinded, cross-over clinical trial with washout period of three weeks between them. The needles were retained for 10 minutes after trigger points stimulation. 'Sham' acupuncture was performed by using needles with tips cut off, and the acupuncturist pretended to insert the needle and to use the sparrow pecking needle manipulation technique. Group A had significantly lower VAS score for pain intensity and Roland Morris Questionnaire scores for pain disability than the sham acupuncture group. However, the beneficial effects were not sustained.

Comment: The sham acupuncture in this trial is different from those of other trials, but does not appear to be very inert. The non-sustained beneficial effect observed was expected as only one treatment was given each time. It is unlikely that all the trigger points could be released with only one session of needling.

27–351 Are minimal, superficial or sham acupuncture procedures acceptable as inert placebo controls?

Lund I, Lundeberg T. Acupunct Med. 2006. Vol.24. No.1. p.13-5.

Reviewed by Dr Alex Chan

Review: An article debating the inertness of minimal, superficial or sham acupuncture as controls in acupuncture clinical trials. The argument was based on the observation that even light touch of the skin could stimulate mechanoreceptors coupled to unmyelinated C fibres resulting in activity in the limbic system and subsequent changes in emotional and hormonal reactions.

Comment: The authors offered a plausible explanation for equivalent effectiveness of 'placebo' acupuncture versus real acupuncture in clinical trials, particularly for pain conditions such as migraine and low back pain which are associated with significant affective components. It probably makes more sense comparing clinical effectiveness of acupuncture with the commonly used analgesics rather than 'placebo' acupuncture.

27–352 Effectiveness of acupuncture and related techniques in treating non-oncological pain in primary healthcare – an audit

Vas J, Aguilar I, Perea-Milla E, et al.
Acupunct Med. 2006. Vol.25. No.1-2. p.41-6.
Reviewed by Dr Alex Chan
Review: This audit was carried out at the Pain Treatment Unit in a primary health care setting within the Spanish Public Health System. Five thousand nine hundred and eighty-one electronically-stored case histories were retrospectively reviewed. Success was defined as an improvement of at least 50% on a Global Assessment Index which was made up of five variables including pain intensity, pain frequency, consumption of analgesics, level of incapacity, and sleep disorders caused by pain. It was found that the majority of patients were women, with pain of more than three months' duration; 58.8% were affected by low back pain. The mean success rate was 79.7%, with highest rate achieved in patients with cephalalgia. The mean reduction in pain intensity amounted to a 67% fall from the baseline. There was a reduction of €7.10 in the mean weekly consumption on analgesic per patient.
Comment: This audit confirmed again that acupuncture was effective in reducing consumption of analgesic in painful conditions. However, the cost of acupuncture itself was not reported.

Alcohol and Substance Abuse

27-353 Supervised injecting facilities: how much evidence is enough?

Maher L, Salmon A. Drug Alcohol Rev. July 2007. Vol.26. No.4. p.351-3.
Reviewed by Dr Helen Moriarty
Review: A short editorial reflecting on the disparity between responsiveness of public health policy and the extent of research done into supervised injecting facilities for injecting drug users. This extremely visible harm reduction initiative has been under debate in Australia since the medically supervised injecting centre was set up in Sydney in 2001. The concept appears to have backing from drug users, health professionals and the broader community, but not from politicians.
Comment: A good example of the control that political expediency holds over rational public health service provision. A much bigger article in the same journal (see 27-354) reports on public opinion on the broader issue of needle and syringe programmes.

27-354 Public opinion on needle and syringe programmes: avoiding assumptions for policy and practice

Treloar C, Fraser S. Drug Alcohol Rev. July 2007. Vol.26. No.4. p.355-61.
Reviewed by Dr Helen Moriarty
Review: See 27-353.

27-355 The efficacy of diversion and after care strategies for adult drug-involved offenders: a summary and methodological review of the outcome literature

Harvey E, Shakeshaft A, Hetherington K, et al. Drug Alcohol Rev. July 2007. Vol.26. No.4. p.379-87.
Reviewed by Dr Helen Moriarty
Review: A literature review of strategies to help drug involved offenders stay away from a relapse to their old behaviours. The key finding was that studies designed to provide evidence about such programmes is of poor quality. Typically with any drug intervention programme there are participation and retention problems, and a major determinant of success is the social stability of clients. The best available evidence suggests that after-prison gains attenuate within a year.
Comment: Drug and alcohol problems (especially drug problems) are commonplace in NZ prisoner populations. This Australian paper throws up a challenge to do better in this area of prison offender diversion, a message that the NZ government should also take seriously.

27-356 Is Australia 'fair dinkum' about drug education in schools?

Midford R. Drug Alcohol Rev. July 2007. Vol.26. No.4. p.421-7.
Reviewed by Dr Helen Moriarty
Review: A discussion paper about the implementation and effectiveness of drug education programmes in schools. Despite prior introduction of several innovative drug education programmes into Australian Schools, there has been little commitment to continuity of delivery and follow-up programmes for those who have had some education.
Comment: On reading this it struck me that NZ is in the same boat – open to criticism about the consistence and continuity of drug and alcohol resistance programmes, leaving decisions over to individual schools rather than mandating national policy.

27-357 Cannabis use and risk of psychotic or affective mental health outcomes: a systematic review

Moore TH, Zammit S, Lingford-Hughes A, et al. Lancet. 28 July-3 August 2007. Vol.370. No.9584. p.319-28.
Reviewed by Dr Tony Hanne
Review: It has long been known that cannabis causes a transient psychotic episode in some patients even on first use. What has been hotly debated is what long-term effect there may be on mental health. This thorough systematic review gives some answers. Those who ever use cannabis have a 40% greater risk of schizophrenia than never users. More frequent use increases risk. The impact on affective disorders is suggestive but less clear.
Comment: The researchers went to considerable lengths to be sure they were showing a causal relationship not a co-morbidity. It is conceded for example that cannabis users may also be using other substances including alcohol. If so it would be unfair to put all the blame on pot. Similarly are those who are already pre-psychotic more likely to resort to cannabis? The risk of cannabis alone is shown to be real. (see 27-358 and 27-359)

27-358 Rehashing the evidence on psychosis and cannabis

Editorial. Lancet. 28 July-3 August 2007. Vol.370. No.9584. p.292.
Reviewed by Dr Tony Hanne
Review: See 27-357 and 27-359.

27-359 Cannabis use and risk of psychosis in later life

Nordentoft M, Hjorthoj C. Lancet. 28 July 2007. Vol.370. No.9584. p.293.
Reviewed by Dr Tony Hanne
Review: See 27-357 and 27-358.

Anaesthesia

27-360 Lifting the fog around anesthesia

Orser BA. Sci Am. June 2007. Vol.296. No.6. p.32-9.
Reviewed by Dr Ron Vautier
Review: Investigations of anaesthetics' underlying mechanisms are revealing that individual aspects of the anaesthetised state – sedation, unconsciousness, immobility, amnesia, analgesia and muscle relaxation – are attributable to different sets of nerve cells which are distinguished by different surface protein receptors. This article looks particularly at receptors for the inhibitory neurotransmitter GABA, which appear to play the central role in anaesthesia. It is suggested that future drugs will be very specifically targeted at the above individual aspects.
Comment: Well written at a level we can readily comprehend, and beautifully illustrated. I certainly recommend it to any practitioner with an interest in anaesthesia, and also to those who would desire a better grasp of the fundamental biochemistry of pharmacology.

Asthma

27-361 Randomized comparison of strategies for reducing treatment in mild persistent asthma

The American Lung Association Asthma Clinical Research Centers. N Engl J Med. 17 May 2007. Vol.356. No.20. p.2027-39.
Reviewed by Dr Raina Elley
Review: Inhaled fluticasone (100mcg BD) can be stepped down to once daily 100mcg fluticasone plus salmeterol when mild asthma is well controlled without causing worsening of symptoms or precipitating early treatment failure (urgent medical visit, oral corticosteroid course or hospitalisation for asthma, or substantial drop in respiratory function). However, replacing the inhaled fluticasone with the oral leukotriene modifier, montelukast, once daily increased the rate of treatment failure (hazard ratio for both comparisons: 1.6 (95%CI 1.1 to 2.6)). This three-arm, double-blind RCT involved 500 patients (over six years of age, mean 31 years) followed for 16 weeks.
Comment: This trial supports advice in guidelines to step-down inhaled steroid use when mild asthma is well-controlled.

Cardiovascular System

27-362 Optimal medical therapy with or without PCI for stable coronary disease

Boden WE, O'Rourke RA, Teo KK, et al. N Engl J Med. 12 April 2007. Vol.365. No.15. p.1503-16.
Reviewed by Dr Raina Elley
Review: Percutaneous coronary intervention (PCI) does not reduce the risk of death, myocardial infarction or other major cardiovascular events when added to optimal medical treatment in stable coronary heart disease. This RCT had 2287 people with stable CHD followed for a median period of 4.6 years.
Comment: PCIs such as coronary stent procedures are becoming more common. While there is good evidence that these procedures reduce MIs and death in those who present with acute coronary syndromes, this is not the case in CHD that is well controlled with medication. PCIs have been found to reduce frequency of angina, but if someone is well-controlled and symptom-free on medication, they are not likely to receive additional benefit with respect to CVD outcomes from a PCI.

27–363 Effect of rosiglitazone on the risk of myocardial infarction and death from cardiovascular causes

Nissen SE, Wolski K. N Engl J Med. 14 June 2007. Vol.356. No.24. p.2457-71.
Reviewed by Dr Raina Elley

Review: Treatment with rosiglitazone (Avandia) is associated with increased risk of myocardial infarction with an Odds Ratio of 1.43, (95%CI 1.03 to 1.98) and may be associated with increased risk of death from cardiovascular cause (OR: 1.64 (95% CI 0.98 to 2.74)). The odds ratios were similar whether compared with placebo or with other anti-diabetic medication, suggesting that the increased risk was associated with rosiglitazone and not due to protection from other agents. This was found by a meta-analysis of 42 RCTs involving rosiglitazone.

Comment: Avandia is available in New Zealand (unfunded) as a third line treatment for Type 2 diabetes, particularly in those that are not adequately controlled on Metformin and sulphonylurea. We should be aware of these potential adverse events, especially as an important goal of management of Type 2 diabetes is to reduce the incidence of complications associated with diabetes, the most important one being cardiovascular disease, which is responsible for 65% of deaths in people with diabetes. This medication is associated with an increased risk of MI and possibly with death from CVD. Thiazolidinediones have a chequered history with troglitazone previously being removed for causing hepatotoxicity. The authors are cautious about their findings, as they had limited access to original data from drug company trials and the number of events was not high, but their findings are a worry.

27–364 Evidence-based approach to exercise prescription in chronic heart failure

Selig SE, Hare DL. Br J Sports Med. July 2007. Vol.4. No.7. p.407-8.
Reviewed by Dr Chris Milne

Review: The benefits of moderate exercise appear to outweigh the risks in patients with chronic heart failure. Six months of aerobic training at moderate intensity (60–70% of VO2 max) for up to two and a half hours per week has been shown to reduce end-diastolic volume and end-systolic volume in patients with CHF.

Comment: This is a huge turnaround from 20 years ago where patients were encouraged to rest.

Communicable Diseases, Infections and Parasites

27–365 Hepatitis B immunity in a population of drug and alcohol users

Polizzotto MN, Whelan G. Drug Alcohol Rev. July 2007. Vol.26. No.4. p.417-9.
Reviewed by Dr Helen Moriarty

Review: This study tested 118 clients of a community-based drug and alcohol service to determine the level of Hep B immunity and validity of self-reported immune status. This was the first assessment of Hep B status in such a population since the 1970s. It showed that only 21% were Hep B immune, half of those who thought they were immune were not, and that the universal childhood immunisation for Hepatitis B is not sufficient alone to reach this hard-to-reach population.

Comment: One factor not mentioned in the paper is that the age group (23–60 years) included a high proportion of people who would have been too old to be offered routine childhood vaccination for Hepatitis B when it was first introduced in the late 1970s. The advice of 'don't ask, vaccinate' is flawed, and even paternalistic – the correct advice should of course be 'ask and test and then vaccinate accordingly'.

27–366 Antiviral therapy and prophylaxis for influenza in children

Committee on Infectious Diseases. Pediatrics. April 2007. Vol.119. No.4. p.852-60.
Reviewed by Dr Jocelyn Tracey

Review: A literature review of Tamiflu, Relenza and other antivirals in children aged over one year for both treatment and prophylaxis of flu. Includes information on efficacy and side effects.

Comment: A useful summary of the use of Tamiflu and Relenza in children.

27–367 Therapy for head lice based on life cycle, resistance, and safety considerations

Lebwohl M, Clark L, Levitt J. Pediatrics. May 2007. Vol.119. No.5. p.965-74.
Reviewed by Dr Jocelyn Tracey

Review: This article provides a summary of the life cycle of head lice, when to treat and what to use. Malathion is the most effective treatment in the US due to resistance to other treatments. The role of combs is also mentioned.

Comment: As much information about head lice as either you or any parent will ever need to know.

Contraception and Family Planning

27–368 Making abortion legal, safe and rare

Editorial. Lancet. 28 July-3 August 2007. Vol.370. No.9584. p.291.
Reviewed by Dr Tony Hanne

Review: This editorial comments on a World Report (See 27-369) in the same issue on the status of abortion law worldwide. The debate between those who want abortion under all circumstances to be illegal and those who want the mother to be allowed unfettered choice is as hot and divisive as ever. A few countries ban abortion altogether and have high rates of illegal and unsafe abortions with horrific consequence in maternal morbidity and mortality. Some countries encourage unrestricted abortion. Most dither in between but in practice abort one pregnancy in five. The silent majority are uneasy about this too.

Comment: Former President Bill Clinton said 'abortion should be legal, safe and rare.' For much of the world it is illegal, unsafe and common. Most of us hold strong philosophical convictions on abortion which are not going to be given up lightly. Caught in between are moth-

ers, fathers and unborn babies. Should there be a meeting point for their sake?

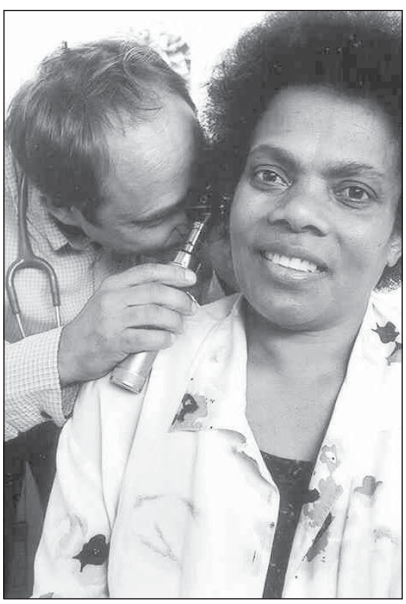
27–369 Abortion debate heats up in Latin America

Replogle J. Lancet. 28 July - 3 August 2007. Vol.370. No.9584. p.305-6.
Reviewed by Dr Tony Hanne
Review: See 27-368.

Dermatology

27–370 Psoriasis 1: Pathogenesis and clinical features of psoriasis

Griffiths CE, Barker JN. Lancet. 21-27 July 2007. Vol.370. No.9583. p.263-84.
Reviewed by Dr Tony Hanne
Review: This two-part series (see 27-371) is a comprehensive review of the pathology, clinical features, and management of psoriasis. The article describes the genetic basis, some provoking factors, the variety of forms, and co-morbidities which surprisingly include cardiovascular disease. Treatment depends on severity which is defined in terms of percentage body surface affected. It still begins with topical corticosteroids and vitamin D derivatives, some much older treatments, UV light of the appropriate wave length, and occlusion. What is new is the wide variety of systemic agents, nearly all of which carry major hazards, being employed in severe psoriasis.
Comment: Next year will be 200 years since the first accurate description of psoriasis. The cause in any individual is still something of a mystery. Treatment is still a lottery. The need for good GP support of the whole person who may be struggling with the psychosocial consequence is as great as ever.



27–371 Psoriasis 2: Current and future management of psoriasis

Menter A, Griffiths CE. Lancet. 21-27 July 2007. Vol.370. No.9583. p.272-84.
Reviewed by Dr Tony Hanne
Review: See 27-370.

Diabetes

27–372 Should you put all diabetic patients on statins?

Leiter L. J Fam Pract. April 2007. Vol.56. No.4. p.294-300.
Reviewed by Dr Bruce Adlam
Review: Evidence-based review. Practice recommendations: Statins are the therapy of choice for lowering LDL cholesterol in patients with diabetes (A). All diabetes patients over the age of 40 should receive statin therapy, regardless of baseline LDL cholesterol (A). Diabetes patients experience greater cardiovascular benefit from aggressive lipid-lowering therapy than from more moderate lipid-lowering therapy (B).
Comment: Quite a substantial study which reviews a number of large trials. The bottom line is that we are probably under-treating.

Ear, Nose and Throat

27–373 Delayed insertion of ear tubes doesn't impair children

J Fam Pract. April 2007. Vol.56. No.4. p.269.
Reviewed by Dr Bruce Adlam
Review: No, delayed tympanostomy tube insertion does not result in any developmental or other impairment. In fact, the delay helps many children avoid tubes altogether. There was no differences between groups in the results of a broad range of tests, including evaluation of hearing, reading, oral fluency, auditory processing, phonological processing, behaviour, or intelligence. There was also no difference between these groups and a group of children with ear problems that weren't bad enough to qualify them for the study. (Original article reviewed: N Engl J Med 2007; 356:248-261).

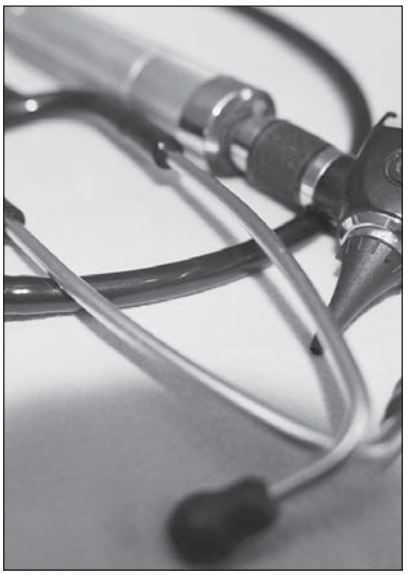
27–374 Tympanostomy tubes and developmental outcomes at nine to 11 years of age

Paradise JL, Feldman HM, Campbell TF, et al. N Engl J Med. 18 January 2007. Vol.356. No.3. p.248-61.
Reviewed by Dr Jocelyn Tracey
Review: Six thousand three hundred and fifty children were followed from birth and monitored regularly for OME. Four hundred and twenty-nine children with persistent OME were randomised to immediate grommets, or insertion after nine months if the effusion persisted. At nine to 11 years of age there were no significant differences on 48 developmental measures between the two groups.
Comment: Another article on the debate about the long-term effectiveness of grommets.

Emergency Medicine

27–375 Weekend versus weekday admission and mortality from myocardial infarction

Kostis WJ, Demissie K, Marcella SW, et al. N Engl J Med. 15 March 2007. Vol.356. No.11. p.1099-109.
Reviewed by Dr Raina Elley
Review: Being admitted for your first myocardial infarction on the weekend rather than on a weekday means you are less likely to receive invasive cardiac procedures acutely and are more likely to die both straight after discharge and up to one month later, unless you were one of the lucky ones to receive an invasive procedure, acutely. This retrospective



study audited hospital notes from 1987 to 2002 (231 164 admissions) in the US.

Comment: Although this is a study from the US, similar studies looking at a range of procedures and adverse outcomes have found similar trends in other parts. The reasons are to do with weekend staffing, which an accompanying editorial critiques (see 27-376). Results are quite likely to be similar in New Zealand.

27–376 Weekend worriers

Redelmeier DA, Bell CM. N Engl J Med. 15 March 2007. Vol.356. No.11. p.1164-5.

Reviewed by Dr Raina Elley

Review: This editorial discusses the adverse effects of lower availability of expertise and staffing in hospitals on weekends on a number of medical conditions, stating that no amount of heroics on Monday will make up for the lack of staff over the weekend. As a possible solution, the authors use the analogy of an oil refinery that pays double-time on weekends, week-day time off and creative flexible schedules to make weekend work more attractive, which is apparently much more economical than purchasing more equipment to boost weekday production. This is in contrast to the low incentives health care workers receive to work weekends (e.g. 10% increased hourly rate).

Comment: Although health care is not profit-driven, it should be quality-driven, and perhaps these incentives and funding are what it takes. General practice weekend work pays little, if any, weekend bonus, and in the case of rural general practice, pays markedly lower hourly rates than during the week, but cover is ensured by contractual obligations. No wonder we do our weekend (and night) duty reluctantly. And no wonder we send many of our high risk patients in on the Friday, instead of waiting for an urgent admission on the weekend. But then the authors of this rather amusing editorial do conclude that if there is an emergency on the weekend, patients are far safer receiving weekend hospital care than staying at home! (See also 27-375)

Endocrinology

27–377 Do testosterone injections increase libido for elderly hypogonadal patients?

Shah K, Montoya C. J Fam Pract. April 2007. Vol.56. No.4. p.301-3.

Reviewed by Dr Bruce Adlam

Review: Evidence-based answer. Yes, testosterone therapy is effective in improving libido for elderly hypogonadal males (strength of recommendation (SOR: B)). Testosterone combined with estrogen can also improve libido for postmenopausal women, but it's not approved by the US-FDA for this purpose (SOR: B). Sexual dysfunction is a relatively frequent complaint from elderly patients, and its multifactorial nature should be investigated. If low or hypogonadal testosterone levels in a male patient is discovered as the cause, consider offering replacement therapy. Discuss the risks and the alternatives (including psychological aspects of care and partner communication). In postmenopausal women interested in combination estrogen and testosterone therapy, the estimated 17% increased risk of breast cancer per year of use needs to be considered and discussed.

Comment: Sample size in these studies was small and did not have sufficient power to detect either meaningful gains in patient-important outcomes or changes in prostate or cardiovascular event rates. Thus, the long-term benefit/risk ratio of testosterone replacement therapy for ageing hypogonadal men is unknown.

Gastroenterology

27–378 Managing nonalcoholic fatty liver disease – Recommendations for family physicians

Grattagliano I, Portincasa P, Palmieri VO, et al. Can Fam Physician Med Fam Can. May 2007. Vol.53. p.857-63.

Reviewed by Dr Mike Lyons

Review: The authors (from Bari University in Italy) outline an integrated approach to this condition that affects 20–40% of our patients! Pathogenesis, natural history, evaluation, general recommendations and treatment are outlined. Screening not warranted – phew!

Comment: Easy article to read and helpful to refer to – especially if you wish to know the difference between NAFLD (Non alcoholic fatty liver disease) and NASH (non alcoholic steatohepatitis). Gives formula to calculate insulin resistance by HOmeostasis Model Assessment (HOMA).

Haemic and Lymphatic Systems

27–379 Clinical perspectives in lymphoma

Young GA, Iland HJ. Intern Med J. July 2007. Vol.37. No.7. p.478-84.

Reviewed by Dr Helen Moriarty

Review: An overview of Hodgkin and other lymphomas. The link with EBV is not completely understood. Staging disease remains important but genetic profile can also aid prognosis. The optimal treatment has been established for many years, but an emerging picture of post transplant lymphoma risk responsive to cessa-

tion of anti-rejection medications has raised an interesting therapeutic dilemma in this particular subgroup of lymphoma patients.

Men's Health

27-380 Male sex: a major health disparity

Salzman BE, Wender RC. Prim Care. March 2006. Vol.33. No.1. p.1-16.
Reviewed by Dr M Hewitt
Review: Major changes in health care research and improvement in maternal morbidity and mortality means men are now the disadvantaged gender for health outcomes.
Comment: An overview and the start of a reasoned approach to improve outcomes for men's health.

27-381 The social and behavioral foundations of men's health – a public health perspective

Plumb JD, Brawer R. Prim Care. March 2006. Vol.33. No.1. p.17-34.
Reviewed by Dr M Hewitt
Review: This article is an overview of all the significant and relevant factors which make for adverse outcomes and health disparities for men. In particular, the effect of male behaviour, as well as race, poverty and intellectual status, on health.
Comment: Intellect modifies behaviour and can prevent adverse outcomes. Can learning do the same for those not so intellectually endowed?

27-382 Health disparities in African American males

Witt DK. Prim Care. March 2006. Vol.33. No.1. p.35-43.
Reviewed by Dr M Hewitt
Review: Although men have higher mortality than women, among men African-Americans have the highest mortality overall. They have more cancer, heart disease and infections than white men. They do have lower suicide rates.
Comment: It is uncertain what factors contribute most to the disparities mentioned above. Race is certainly genetic, but some authorities

argue that socioeconomic factors are definitive contributors to adverse outcomes.

27-383 Hispanic male health disparities

Diaz VA. Prim Care. March 2006. Vol.33. No.1. p.45-60.
Reviewed by Dr M Hewitt
Review: As with African-American males, the major causes of mortality are listed and discussed with regard to predisposing factors.
Comment: Culture and economic factors are considered to be major contributors to adverse outcomes.

27-384 Common sexual health issues in men

Winn RJ. Prim Care. March 2006. Vol.33. No.1. p.61-74.
Reviewed by Dr M Hewitt
Review: The author discusses the effects of sexually transmitted diseases, biological functions and sexual orientations on male health outcomes.
Comment: Behaviour determines the bulk of adverse health outcomes.

27-385 Assessment and management of cardiovascular risk in men

McBride PE, Ryan G. Prim Care. March 2006. Vol.33. No.1. p.75-91.
Reviewed by Dr M Hewitt
Review: Cardiovascular disease is the leading cause of death and disability for men in the United States. The authors discuss how to assess and advise on management strategies to minimise the risk of heart disease in men.
Comment: Us too!

27-386 Assessment and management of lipid disorders in men

Haines CA, Collins LG, Nimoityn P. Prim Care. March 2006. Vol.33. No.1. p.93-114.
Reviewed by Dr M Hewitt
Review: This is a part of the overall strategy involved in diminishing risk from cardiovascular disease. Treatment to lower cholesterol is discussed.
Comment: Mainly statins.

27-387 Cancer screening in men

Gates TJ, Beelen MJ, Hershey CL. Prim Care. March 2006. Vol.33. No.1. p.115-38.
Reviewed by Dr M Hewitt
Review: Cancer deaths are number two after heart disease both in the United States and New Zealand. The big three being lung, colon and prostate which account for 51% of cancer deaths in men in the U.S. The authors look at current recommendations.
Comment: As in New Zealand, screening for prostate cancer with the use of PSA is debatable. Eating healthy food and stopping smoking account for the rest.

27-388 Step-by-step lifestyle changes that can improve urologic health in men, part I: what do I tell my patients?

Moyad MA. Prim Care. March 2006. Vol.33. No.1. p.139-63.
Reviewed by Dr M Hewitt
Review: The author details the problem areas of benign prostatic hypertrophy, prostate cancer and erectile dysfunction, then makes a series of recommendations to the patients. The advice given involves realistic diet and lifestyle changes as well as medication and surgery.
Comment: Problems of these types are common and lifestyle changes significantly enhance the quality of life for those men concerned. (See 27-389)

27–389 Step-by-step lifestyle changes that can improve urologic health in men, Part II. What do I tell my patients?

Moyad MA. Prim Care. March 2006. Vol.33. No.1. p.165-85.

Reviewed by Dr M Hewitt

Review: See 27-388.

27–390 Violence and men's health

Stringham P. Prim Care. March 2006. Vol.33. No.1. p.187-97.

Reviewed by Dr M Hewitt

Review: Homicide features highly among the likely causes of death of males. The author discusses ways primary care providers can address the issue.

Comment: A political solution is required in the United States.

27–391 Intimate partner violence and men's health

Cronholm PF. Prim Care. March 2006. Vol.33. No.1. p.199-209.

Reviewed by Dr M Hewitt

Review: As with homicide, biology and culture play a significant role in the violent behaviour of men.

Comment: Primary care providers can help with relationship issues, as well as the usual suspects of drugs, alcohol and jealousy.

27–392 Managing depression and suicide risk in men presenting to primary care physicians

Blashki G, Pirkis J, Morgan H, et al. Prim Care. March 2006. Vol.33. No.1. p.211-21.

Reviewed by Dr M Hewitt

Review: Men are not frequent attenders for problems of this sort so the primary care provider must be vigilant and anticipatory in care. The author discusses risk factors as indicators and active management.

Comment: Although men are less likely to attempt suicide, they are more likely to succeed than women.

27–393 Neurocognitive development in adolescent males or adolescent boys are from Pluto

Brisbon N, Chambers CV. Prim Care. March 2006. Vol.33. No.1. p.223-36.

Reviewed by Dr M Hewitt

Review: The authors compare and contrast the differences between adolescent boys and girls with regard to developing health care strategies to minimise risky behaviour. They use much information based on the neurophysical chemical changes occurring in the adolescent period, and the effects these changes have on cognitive development and subsequent behaviour.

Comment: A good review, building on information given at CME level by Professor John Newman.

Musculoskeletal System

27–394 Hip arthroscopy: current concepts and review of literature

Shetty VD, Villar RN. Br J Sports Med. February 2007. Vol.41. No.2. p.64-8.

Reviewed by Dr Chris Milne

Review: Hip arthroscopy has improved our diagnosis of complex hip problems, many of which were previously unrecognised. It has allowed surgeons to treat conditions such as femoro acetabular impingement, with minimal access to the joint.

Comment: A state of the art summary of this emerging investigation and treatment modality.

Nutritional and Metabolic Diseases

27–395 Weight loss and health outcomes in African Americans and Whites after gastric bypass surgery

Anderson WA, Greene GW, Forse RA, et al. Obesity. June 2007. Vol.15. No.6. p.1455-63.

Reviewed by Dr Anne-Thea McGill

Review: This was a retrospective database review of a sample of 84 adult patients, BMI=54 (24 African-American and 60 white women and men) between the ages of 33 and 53 years. All participants had gastric bypass weight loss surgery in 2001 at the Bariatric Surgery Program at Boston Medical Center in Boston, MA, and were followed for one year postoperatively. Patients were excluded if weight data were missing at baseline, three months, or one year after GBP. A total of nine African Americans and 41 whites provided data at all three time-points and were included in the study. Differences in weight loss, diet, and cardiovascular risk factors were analysed. More blacks were diabetic. Blacks lost 26 +/- 10% and whites 39 +/- 8% of initial weight, with whites losing more quickly. Co-morbidity improvement was the same in both groups. The researchers reviewed total and protein energy intake post op. which was similar and concluded that there were racial differences. A critique of this study showed no demographic detail on cultural practices or socioeconomic differences between blacks and whites. The researchers glossed over the higher data loss rate in blacks. They did not mention fruit and vegetable intake, known to help in weight loss and to be less in black people and lower socioeconomic groups.

Comment: As New Zealand opens up bariatric surgery in public hospitals, cost for the individual is reduced, and people of different races, cultures and socioeconomic status become eligible. We should not rush to blame racial physiology at the expense of planning for and managing sociocultural differences post gastric bypass surgery.

Orthopaedics

27–396 A randomized, controlled trial of a removable brace versus casting in children with low-risk ankle fractures

Boutis K, Willan AR, Babyn P, et al. Pediatrics. June 2007. Vol.119. No.6. p.1183-91.

Reviewed by Dr Jocelyn Tracey

Review: One hundred and four 5–18-year-olds with distal fibula fractures were randomised for treatment with brace or plaster cast for four weeks. Those fitted with braces had higher mean activity scores and greater return to baseline activity at four weeks. The braces were also more cost-effective and preferred by patients.

Comment: Having personally had brace treatment for a distal fibula fracture this year, (n=1), I would agree heartily with the outcomes of this study!

Paediatrics

27-397 What's the best treatment for cradle cap?

Sheffield RC, Crawford P, Wright ST. J Fam Pract. March 2007. Vol.56. No.3. p.232-3.
Reviewed by Dr Bruce Adlam
Review: Ketoconazole (Nizoral) shampoo appears to be a safe and efficacious treatment for infants with cradle cap. Limit topical corticosteroids to severe cases because of possible systemic absorption. Some experts advise against the use of steroids. Overnight application of emollients (mineral oil) followed by gentle brushing and washing with baby shampoo helps to remove the scale associated with cradle cap (all SOR: C). Cradle cap is a form of seborrheic dermatitis that manifests as greasy patches of scaling on the scalp of infants between the second week and sixth month of life. Untreated, it usually resolves at eight months.
Comment: It's generally nonpruritic and doesn't bother the infant, though it can be a stressor for parents.

Palliative Care

27-398 Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care

Chochinov HM. BMJ. 28 July 2007. Vol.335. No.7612. p.184-7.
Reviewed by Dr Peter Woolford
Review: Dignity is defined as 'the state of being worthy of honour or respect'. The EU charter recognises dignity as a human right. But how to achieve dignity in medical care? Harvey Chochiniv (Canada) offers a straightforward framework to help clinicians achieve dignity conserving care. He uses a simple A (Attitude), B (Behaviour), C (Compassion), D (Dialogue) mnemonic to help us care for our patients. As Frances Peabody wrote in 1927, *'one of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.'*
Comment: Although this paper has arisen out of palliative care, it has insights for every one of us. An excellent paper to direct students to. By co-incidence negotiations are happening to bring Prof. Chochinov to NZ early next year. (See 27-399)

27-399 Rediscovering dignity at the bedside

Higginson IJ, Hall S. BMJ. 28 July 2007. Vol.335. No.7612. p.167-8.
Reviewed by Dr Peter Woolford
Review: See 27-398.

27-400 Sensitivity and specificity of a two-question screening tool for depression in a specialist palliative care unit

Payne A, Barry S, Creedon B, et al. Palliative Med. April 2007. Vol.21. No.3. p.193-8.
Reviewed by Dr Peter Woolford
Review: In the palliative care setting depression is difficult to consider and then diagnose. Clearly it is important to consider as there are effective treatments available that may have a big impact on quality of life for the patient and the family. *'Are you depressed?' 'Have you experienced a loss of interest in things of activities that you would normally enjoy?'* These questions have a high sensitivity and a low false negative rate and therefore are valid as a screening tool.
Comment: This was based in a specialist inpatient unit, but it is a good reminder for us to consider depression in palliative patients.

27-401 Shifting to conscious control: psychosocial and dietary management of anorexia by patients with advanced cancer

Shragge JE, Wismer WV, Olson KL, et al. Palliative Med. April 2007. Vol.21. No.3. p.227-33.
Reviewed by Dr Peter Woolford
Review: Anorexia is a common and often distressing problem for dying patients and their families. Anorexia is not well understood from a medical point of view. Intuitively, maintaining a balanced food intake must help but it is not clear how to encourage this. Nutritionists help but this paper looks at some of the psychosocial issues around anorexia.
Comment: The bottom line for this study seems to be encouraging patients and carers to understand that *'I can't eat'* may mean *'I have to make a conscious decision to eat.'* In other words cachexia may take away the unconscious drive to eat and this may need to be consciously encouraged. This is a small early study, but gives good pointers in a different direction.

27-402 Patient evaluation of end-of-life care

de Vogel-Voogt E, van der Heide A, van Leeuwen AF, et al. Palliative Med. April 2007. Vol.21. No.3. p.243-8.
Reviewed by Dr Peter Woolford
Review: The Netherlands has a strong primary care system and a high home death rate for palliative patients. As such, various indicators have been developed to measure quality of care at the end of life. Many of these indicators have not been successful. However, one indicator amenable to quality improvement and that which can be used as a quality indicator of end of life care is patient satisfaction. In palliative care this is not often used in a re-

search situation. This is one study that has chosen to look at patient satisfaction in depth. Most patients were satisfied with their care but some areas were highlighted. Difficulties in getting a response from health care professionals in acute situations, co-ordinating different health professionals, information giving, emotional support and being treated with respect (dignity – see the Chochinov paper (27-398)) were the areas patients felt could do with improvement.

Comment: A rare paper asking dying patients directly about their experiences. Good paper.

Psychiatry and Psychology

27–403 How should we treat major depression combined with anxiety?

Trotter B, Kelsberg G, St. Anna L, et al. J Fam Pract. April 2007. Vol.56. No.4. p.306-8.

Reviewed by Dr Bruce Adlam

Review: Evidence-based answer. One approach is to use antidepressants alone, which reduces symptoms for patients with major depression plus symptoms of anxiety or major depression plus generalised anxiety disorder. Selective serotonin reuptake inhibitors (SSRIs), tricyclics (TCAs), bupropion, mirtazapine, nefazodone, and venlafaxine are equally effective for combined symptom relief (strength of recommendation [SOR]: A, based on systematic review of randomised controlled trials [RCTs]). Another approach is to add a benzodiazepine to the antidepressant for a brief period. This reduces anxiety symptoms (more in the short-term) and decreases patient dropout, but it also has possible harms, including dependence, altered cognition, tolerance, abuse potential and accident proneness (SOR: A, based on systematic review of RCTs). Psychotherapy, particularly cognitive behavioral therapy, produces and maintains reductions in symptoms of anxiety and depression that are comparable with the reductions seen with medication (SOR: A, based on systematic review of RCTs).

27–404 The memory code

Tsien JZ. Sci Am. July 2007. Vol.297. No.1. p.34-41.

Reviewed by Dr Ron Vautier

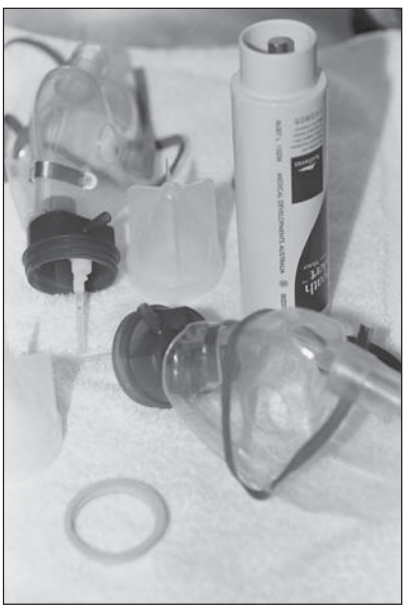
Review: This article looks at how researchers are trying to make sense of the data obtained when they record simultaneously from hundreds of electrodes inserted into individual neurons of the hippocampus of awake, free-moving mice subjected to various startling experiences. Analysis reveals that the neurons are sorted into different groups that respond differentially to the different aspects of an event. Thus it appears that such neural 'cliques' serve as the functional coding units that give rise to memories.

Comment: The above brief summary no doubt fails to do justice to what the article conveys. In any case, what we are considering is of no current practical import, but it should appeal to, and reward, anyone neuroscientifically inclined.

27–405 Computerised therapy for psychiatric disorders

Christensen H. Lancet. 14-20 July 2007. Vol.370. No.9582. p.112-3.

Reviewed by Dr Tony Hanne



Review: For several years it has been clear from trials that in mild to moderate depression, and particularly in adolescents, cognitive behavioural therapy (CBT), is as least as effective as antidepressants and that it is preferred by many patients. In the UK it is also apparent that the number of therapists in the public health system is totally inadequate. This has led to the development of computer-based, self help programmes for treating depression and anxiety. Now research shows that computerised CBT (cCBT), is just as effective as a face to face therapist.

Comment: 'Necessity is the mother of invention.' This is both exciting and worrying. CBT is simply an organised commonsense system for leading patients to review their intellectual, emotional and volitional status and the path ahead. It is exciting to know that there is an IT way of supporting this when resources are inadequate. At the same time it is worrying because we always thought a wise, caring friend was a vital ingredient. Will we have cGPs next?

Respiratory System

27–406 Salmeterol and fluticasone propionate and survival in chronic obstructive pulmonary disease

Calverley PM, Anderson JA, Celli B, et al. N Engl J Med. 22 February 2007. Vol.356. No.8. p.775-89.

Reviewed by Dr Raina Elley

Review: Combination high dose inhaled fluticasone (500mcg BD) and salmeterol (50mcg BD) may reduce risk of death among COPD patients, compared with placebo, although it did not quite reach statistical significance (three-year all-cause mortality 12.6% versus 15.2%, p=0.052). However, the combination therapy did reduce exacerbations of COPD, and improved health status and lung function when compared with placebo ($p<0.001$). Salmeterol or fluticasone alone did not significantly reduce mortality compared with placebo, but they did reduce

exacerbations, although to a lesser extent than with combination therapy. Those taking fluticasone alone or in combination were more likely to develop pneumonia than with placebo (18.3% and 19.6% versus 12.3%, p<0.001). This multi-centre RCT was conducted with 6112 COPD patients (mean age 65 years, 75% male) followed for three years.
Comment: The study does support combination therapy (fluticasone and salmeterol) in the treatment of COPD.

Rheumatic Diseases

27–407 Predictors of symptomatic response to glucosamine in knee osteoarthrits: an exploratory study

Bennett AN, Crossley KM, Brukner PD, et al. Br J Sports Med. July 2007. Vol.41. No.7. p.415-9.
Reviewed by Dr Chris Milne
Review: Glucosamine has been taken by patients with OA with conflicting reports of its efficacy. A recent Cochrane review found no proven benefits. Sub-group of patients – those with lower BMI, patello-femoral joint osteophytes and lower functional self-efficacy were found to benefit from glucosamine. However, numbers were small (only 39 patients in total).
Comment: This finding is in accord with intuitive reasoning – those with mild or moderate disease who are not seriously overweight could be expected to be the most likely to benefit from glucosamine.

Self Care: Health Professionals

27–408 The long dark night of the sports medicine soul

McCrory P. Br J Sports Med. 1 June 2007. Vol.41. No.6. p.343-45.
Reviewed by Dr Chris Milne
Review: This editorial describes the progression from idealism to cynicism of the editor of a major peer-reviewed sports medicine journal. It also describes the symptoms of burnout, and describes strategies the individual can adopt (e.g. exercise regularly, maintain regular contact with a GP), and also gives recommendations for workplaces and professional bodies.
Comment: Very insightful piece, that has relevance to all clinicians, no matter what their speciality.

Sexually Transmitted Diseases

27–409 Male circumcision for prevention of HIV and other sexually transmitted diseases

Flynn P, Havens P, Brady M, et al. Pediatrics. April 2007. Vol.119. No.4. p.821-2.
Reviewed by Dr Jocelyn Tracey
Review: The authors review the evidence for male circumcision reducing the rate of both STDs and HIV. They conclude that circumcision is a *'medically rational choice that should be included in government health or insurance benefits'*.
Comment: Interesting...

Sports and Exercise Medicine

27–410 Determining the intensity and energy expenditure during commuter cycling

de Geus B, De Smet S, Nijs J, et al. Br J Sports Med. January 2007. Vol.41. No.1. p.8-12.
Reviewed by Dr Chris Milne
Review: As the world's energy supplies run down, many authorities are recommending that commuters consider cycling to and from work. This Belgian group studies 18 healthy middle-aged people who cycled to and from work on at least three days per week, for 12 weeks. They consumed significant energy, averaging 1811 kcal per week for the men, and 1200 kcal per week for the women.
Comment: Cycling would appear to be a useful alternative to other forms of transport, and can make valuable contributions to weight control and aerobic fitness in middle-aged people.

27–411 Blood tests in tired elite athletes: expectations of athletes, coaches and sport science/sports medicine staff

Fallon KE. Br J Sports Med. January 2007. Vol.41. No.1. p.41-4.
Reviewed by Dr Chris Milne
Review: Athletes presenting with fatigue are amongst the most difficult people to evaluate. Athletes and their coaches generally expect that blood tests will be performed, even if fatigue has been present for less than one week. Blood tests of most use are the full blood count (to check for anaemia or infection) and ferritin (to exclude iron deficiency).
Comment: As doctors, we are well aware that blood tests have limited utility – most cases of athletic fatigue are caused by excessive training and sleep problems.

27–412 A stitch in time

McCrory P. Br J Sports Med. March 2007. Vol.41. No.3. p.125.
Reviewed by Dr Chris Milne
Review: The editor, Paul McCrory recalls his school days, when getting 'the stitch' during school sports was a common event. Now the condition has been renamed Exercise-Related Transient Abdominal Pain (ETAP). Advice for avoiding it remains the same – eat well before exercise, and avoid high osmolality drinks. If a stitch occurs, stop, bend over and tighten the abdominal muscles.
Comment: Good succinct article about a condition that can be a real nuisance for our young athletes.

27–413 Topical ketoprofen TDS patch versus diclofenac gel: efficacy and tolerability in benign sport related soft-tissue injuries

Esparza F, Cobian C, Jimenez JF, et al. Br J Sports Med. March 2007. Vol.41. No.3. p.134-9.
Reviewed by Dr Chris Milne
Review: Topical NSAIDs have an increasing evidence base. This study showed that a Ketoprofen patch applied once daily is at least as effective as the diclofenac gel, which is widely used in New Zealand. Once daily use would probably help compliance.
Comment: In general terms, the more superficial and local the injury is, the more likely it is that a topical NSAID will be effective.

27–414 A treatment algorithm for managing Achilles tendinopathy: new treatment options

Alfredson H, Cook J. Br J Sports Med. April 2007. Vol.41. No.4. p.211-6.
Reviewed by Dr Chris Milne

Review: In the past decade, treatment of Achilles tendinopathy has undergone a profound sea-change. Now, the best evidence-based practice is to get the patient to do a progressive concentric then eccentric strengthening regime. In recent times, the source of pain has been found to be related to new vessels growing into the tendon in a failed healing response to injury.

Comment: This article by two of the world's leading researchers in tendinopathy is a must-read for all clinicians treating people with Achilles tendon problems.

27–415 Is there a link between malignant hyperthermia and exertional heat illness?

Hopkins PM. Br J Sports Med. May 2007. Vol.41. No.5. p.283-4.
Reviewed by Dr Chris Milne

Review: Malignant hyperthermia and exertional heat illness are both acute life-threatening disorders. They share common clinical features of tachycardia, rhabdomyolysis and hyperthermia. However, only a minority of people with exertional heat illness have an underlying skeletal muscle defect, and most people with a history of malignant hyperthermia need not modify their physical activity.

Comment: Useful article providing an update on two important clinical conditions.

27–416 Consensus statement on injury definitions and data collection procedures for studies of injuries in rugby union

Fuller CW, Molloy MG, Bagate C, et al. Br J Sports Med. May 2007. Vol.41. No.5. p.328-31.
Reviewed by Dr Chris Milne

Review: Compared to other football codes such as soccer and gridiron (American football) historically, there has been a relative dearth of information on rugby injuries. Fortunately, with extensive video analysis of injuries in professional games, this situation is now being remedied. This article describes how to record such injuries so as to conform to internationally agreed standards.

Comment: As rugby is New Zealand's national sport this information is important for clinicians looking after rugby players at any level, not just elite teams.

27–417 Effects of a maximal exercise test on neurocognitive function

Covassin T, Weiss L, Powell J et al. Br J Sports Med. June 2007. Vol.41. No.6. p.370-4.
Reviewed by Dr Chris Milne

Review: On-field assessment of potentially concussed athletes is compromised by many factors. Trying to sort out how much is due to their fatigued state from exertion is a big ask. These authors studied 102 recreational athletes and found that those who had just performed a heavy workout had a limiting effect on high level cognitive function.

Comment: This is not surprising, and we should test our athletes after they have had a day or two of rest.

27–418 Is it all too much?

McCrory P. Br J Sports Med. July 2007. Vol.4. No.7. p.405-6.
Reviewed by Dr Chris Milne

Review: The Olympic Games are becoming a progressively more expensive event to run. It is estimated that it will cost the Chinese about US $100 million just to disperse clouds during the Beijing Olympics in 2008. By 2012, it is thought the London Olympics will cost US $18 billion.

Comment: If the costs keep on escalating, it makes it likely that the Olympic Games will either have to return to Athens indefinitely, or go to just a few selected wealthy countries.

27–419 Comparison of three types of full-body compression garments on throwing and repeat-sprint performance in cricket players

Duffield R, Portus M. Br J Sports Med. July 2007. Vol.41. No.7. p.409-14.
Reviewed by Dr Chris Milne

Review: Compression garments have been used by our vascular patients for years. Now they are being promoted for use by athletes. This study tries to establish whether the hype is justified. In the study, there was no improvement in throwing or repeat-sprint performance.

Comment: It seems that the benefit may be mainly placebo. Lots of athletes wear them for travel on long flights and claim to be able to train more effectively soon after arrival. Whether this anecdotal evidence translates into statistically proven fact remains to be seen.

Sports and Sports Medicine

27–420 Long-standing groin pain in sportspeople falls into three primary patterns, a 'clinical entity' approach: a prospective study of 207 patients

Holmich P. Br J Sports Med. April 2007. Vol.41. No.4. p.247-52.
Reviewed by Dr Chris Milne

Review: Groin pain is common in athletes. In footballers or other athletes who perform cutting activities, most groin pain arises from the adductor tendon. In runners, who perform straight line activity, the iliopsoas tendon is the commonest source of pain, followed by rectus abdominis related dysfunction.

Comment: Most current review articles consider groin pain in athletes to be a progressive overload problem, and can get unnecessarily complex. This article, based on 207 patients brings back some simplicity and is therefore appealing.

Therapeutics

27–421 How effective are hypertension self-care interventions?

Viera AJ, Jamieson B. J Fam Pract. March 2007. Vol.56. No.3. p.229-314.
Reviewed by Dr Bruce Adlam

Review: Simplification of the dosing regimen (e.g. once-daily instead of multiple dosing) improves medica-

tion taking compliance (SOR: B). Dietary advice promotes modest short-term improvements in self-reported fat intake and fruit and vegetable consumption (SOR: B). Educational interventions alone, in general, do not improve patient medication-taking compliance and physicians' advice to increase physical activity is not effective, even as part of a self-care plan for hypertension (SOR: B, based on one randomised trial).

27–422 Long-term use of proton pump inhibitors raised hip fracture risk

J Fam Pract. April 2007. Vol.56. No.4. p.274.
Reviewed by Dr Bruce Adlam

Review: The long-term use (>1 year) of PPIs is associated with an increased risk of hip fracture among adults older than 50 years (adjusted hazard ratio=1.44 [95% confidence interval, 1.30-1.59]; number needed to harm per person-years=1266 [95% CI, 944-1856]). The associated risk was further increased among patients taking higher doses of a PPI and with increasing duration of use. Histamine-2 receptor antagonist therapy (e.g. ranitidine, cimetidine) did not significantly increase hip fracture risk. (Original article reviewed: JAMA 2006; 296:2947-2953)

Comment: The significant hypochlorhydria as a result of PPI therapy may cause calcium malabsorption, resulting in the higher risk of bone fractures.

Urology

27–423 Pathologic and physiologic phimosis: Approach to the phimotic foreskin

McGregor TB, Pike JG, Leonard MP. Can Fam Physician Med Fam Can. March 2007. Vol.53. p.445-8.
Reviewed by Dr Mike Lyons

Review: The authors work in the Paediatric Urology Department, Ottawa and with an illustrative case history and two photos (that will reproduce less faithfully in black when photocopied) guide GPs in the care of phimosis with an eminently practical approach. It helps parents to know 10% of foreskins at three years remain non retractile and only 1% at 16 years. Few are pathological. Indications for Urology referral are few but precise. The remedy for physiological phimosis is 'tincture of time'.

Comment: Would be a useful article to store for distribution to parents of first born boys.

Vaccination and Vaccines

27–424 Cost-effectiveness and potential impact of rotavirus vaccination in the United States

Widdowson M-A, Meltzer MI, Zhang X, et al. Pediatrics. April 2007. Vol.119. No.4. p.684-97.
Reviewed by Dr Jocelyn Tracey

Review: If rotavirus were added to the immunisation regime at two, four and six months the cost would be $US138 per case averted, $3,024 per serious case, and $197,190 per life year saved.

Comment: Interesting data in view of the recent vaccine publicity here.

27–425 Prevention of influenza: recommendations for influenza immunization of children, 2006–2007

Committee on Infectious Diseases. Pediatrics. April 2007. Vol.119. No.4. p.846-51.
Reviewed by Dr Jocelyn Tracey

Review: A statement from the American Academy of Pediatrics on childhood flu immunisation. They now recommend flu vaccination for all children from six months of age and also for their parents and care givers. Children under nine years need two doses.

Comment: Useful information to have at your fingertips to be able to answer parental questions.

Virus Diseases

27–426 Quadrivalent vaccine against human papillomavirus to prevent high-grade cervical lesions

The FUTURE II Study Group. N Engl J Med. 10 May 2007. Vol.356. No.19. p.1915-27.
Reviewed by Dr Raina Elley

Review: Human papilloma virus (HPV) vaccine (for types 6,11,16,18) has 98% efficacy for prevention of CIN2 or 3, adenocarcinoma in situ or cervical cancer related to HPV-16 or 18 in young women (15–26 years) who have not been exposed to HPV previously and who complete the vaccination course. In an intention to treat analysis of all women randomised, including those with previous HPV infection, efficacy was 44% (and 17% for prevention of all high-grade cervical lesions, regardless of causal HPV type). This was a large double-blind phase three RCT of 12 167 women with three-year follow-up.

Comment: This vaccine appears to be highly effective in young women not previously exposed to HPV. It is interesting to see that Australia have acted on this evidence and implemented a HPV immunisation programme for girls. New Zealand has not done so, despite a recent analysis showing that it would be quite cost-effective, with cost-utility estimates around the $20,000/QALY mark, which is about the current threshold for funding pharmaceutical interventions in New Zealand (re: Associate Professor Richard Milne, recent presentation at University of Auckland). A medical student recently reviewed some of the evidence around this vaccine and found that the NNT for prevention of cervical lesions for this vaccine is better when HPV-exposed women are vaccinated along with those not previously exposed than if you gave it to only those not-exposed. This is because the group of women with previous exposure were more likely to develop a cervical lesion and therefore even with a lower vaccine efficacy in this group, more actual lesions were prevented than in the non-exposed group, who had a lower incident rate of cervical lesions. When reading the list of adverse effects in the intervention and control groups, I was a little confused, as the multiple comparisons resulted in some events where there were statistically signifi-

cant increases in the vaccination group (e.g. pain at injection site, congenital abnormality when conception was within 30 days of vaccine) and some where the control group had higher rates (e.g. neck pain, spontaneous abortion when conception was >30 days after vaccination date). Overall, there was no significant difference in total number of serious adverse events between the groups. (See also 27-427)

27-427 Quadrivalent vaccine against human papillomavirus to prevent anogenital diseases

Garland SM, Hernandez-Avila M, Wheeler CM, et al. N Engl J Med. 10 May 2007. Vol.356. No.19. p.1928-43.

Reviewed by Dr Raina Elley

Review: This paper reinforces the findings from the previous paper. There was a significant reduction in HPV-associated anogenital diseases in young women who had received the quadrivalent HPV vaccine compared with placebo in an RCT involving 5455 16–24-year-old women followed for three years.

Comment: With Gardasil (quadrivalent HPV vaccine) now available in New Zealand and with the public wanting to know more about this vaccine, these articles are useful resources to help you answer those questions around effectiveness and adverse events. (See also 27-426)

27-428 Case-control study of human papillomavirus and oropharyngeal cancer

D'Souza G, Kreimer AR, Viscidi R, et al. N Engl J Med. 10 May 2007. Vol.356. No.19. p.1944-56.

Reviewed by Dr Raina Elley

Review: Increasing numbers of sex partners (vaginal or oral sex) is associated with an increased likelihood of developing oropharyngeal cancer, after controlling for smoking as a risk factor. HPV DNA is detected in 72% of tumour specimens.

Comment: HPV can cause other cancers besides cervical cancer.

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