Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Aust Fam Physician*
BMJ*
Br J Sports Med Br J Sports Med*
Can Fam Physician Med Fam*
Int J Obes*
Intern Med J*
J Fam Pract*
J Neuroimmunol*
JAMA*
Lancet*
N Engl J Med*
Pain*
Physician and Sportsmedicine*
Prim Care*
Sci Am*
*Journals indexed in Medline

Acupuncture

25-081 Suppression of IgE production and modulation of Th1/Th2 cell response by electroacupuncture in DNP-KLH immunized mice.

Park M-B, Ko E, Ahn C, et al. J Neuroimmunol. June 2004. Vol.151. No.1-2. p.40-4.

Reviewed by Dr Alex Chan

Review: The study evaluated the effects of electroacupuncture of 1Hz for 20 minutes at ST-36 on antigen-specific IgE production and on Th1/Th2 cell responses in mice immunised with DNP-keyhole limpet protein. Acupuncture was repeated daily for a period of seven, 14, and 21 days. Serum antigen-specific IgE and total IgE were found to be significantly enhanced by seven days EA treatments but reduced by 14 and 21 days of EA treatments. IFN-gamma secretion from splenocytes was not altered by EA treatment but production of the Th-2 specific cytokines IL-4, and IL-13 from splenocyte cultures were significantly suppressed when compared with non-acupunctured immunised mice and controls.

Comment: EA treatments at ST-36 for 14–21 days can affect the immunological reaction of mice. This supports the long held belief of using ST-36 as an immune modifying acupuncture point.

Alcohol and Substance Abuse

25-082 Alcohol and other drug use in later life.

Sim MG, Hulse G, Khong E. Aust Fam Physician. October 2004. Vol.33. No.10. p.820-4.

Reviewed by Dr Rachel Monk

Review: Interesting case-based discussion of a not uncommon problem. This article looks at temazepam and alcohol use in a 73 year old woman who has suffered recent losses. It also has the geriatric depression scale on page 823, which can be a useful resource for assessing depression in the elderly; be it associated with alcohol and drug use or not.

Comment: Don't forget to ask the elderly about drug and alcohol use. It can affect people of any age.

25-083 Benzodiazepine dependence.

Khong E, SIm MG, Hulse G. Aust Fam Physician. November 2004. Vol.33. No.11. p.923-6.

Reviewed by Dr Rachel Monk

Review: Benzodiazepine dependence can occur when benzodiazepines are used as treatment for true anxiety or sleep disturbance, as the case in this article illustrates. The importance of non drug treatment for these conditions and a guide to gradual benzo-

diazepine cessation using diazepam are discussed.

25-084 Acute pain and opioid seeking behaviour.

Sim MG, Hulse GK, Khong E. Aust Fam Physician. December 2004. Vol.33. No.12. p.1009-12.

Reviewed by Dr Rachel Monk

Review: Case based look at how patients can feign acute pain to get opioid analgesia from GPs. Includes some warning signs and suggestions on developing a practice policy on how to deal with suspected (or perhaps unsuspected) 'doctor shoppers'.

Comment: Helpful read – any tips to avoid being 'caught out' are much appreciated.

Alcohol Drinking

25-085 Effects of moderate alcohol consumption on cognitive function in women.

Stampfer MJ, Kang JH, Chen J, et al. N Engl J Med. 20 January 2005. Vol.352. No.3. p.245-53.

Reviewed by Dr Ross McCormick

Review: The authors studied the effect of moderate consumption of alcohol on cognition in women. Between 1995 and 2001 they evaluated cognitive function in 12 480 participants in a Nurses' Health Study who were 70 to 81 years old, with follow-up assessments in 11 102 two years later. The level of alcohol consumption was ascertained regularly, beginning in 1980. They calculated multivariate-adjusted mean cognitive scores and multivariate-adjusted risks of cognitive impairment and a substantial decline in cognitive function over time. Moderate drinkers (those who consumed less than 15.0g of alcohol per day) had better mean cognitive scores than nondrinkers. The results for cognitive decline were similar.

Comment: This study suggests that in women, up to one drink per day over a prolonged time period does not impair cognitive function and may actually decrease the risk of cognitive decline. Clearly this study is about moderate safe alcohol drinking and not excessive drinking where we all know the consequences. The study is also about nurses and I wonder if that is a confounder – possibly not.

Asthma

25-086 Changes in recommended treatments for mild and moderate asthma.

Redding GJ, Stoloff SW. J Fam Pract. September 2004. Vol.53. No.9. p.692-700.

Reviewed by Dr Bruce Adlam

Review: Quite a good article that reinforces the use of inhaled corticosteroids with persistent asthma before the use of the alternatives; leukotriene modifiers, cromolyn, and nedocromil. Inhaled corticosteroids are safe, with normal doses, in terms of growth, cataracts and glaucoma.

Comment: Long acting beta agonists should not be used as monotherapy. There's more on the newer classification of asthma and a stepwise approach to management

Cardiovascular System

25-087 Recent developments in atrial fibrillation.

Iqbal MB, Taneja AK, Lip GY, et al. BMJ. 29 January 2005. Vol.330. No.7485. p.238-43.

Reviewed by Dr Len Brake

Review: This most commonly encountered arrhythmia in general practice is associated with substantial morbidity and mortality. The article highlights new approaches to management. It is one of the more important and valuable updates I have seen recently. A few notes: anticoagulation is crucial; warfarin is UNDER prescribed; the oral thrombin inhibitor ximelagatran is as effective as warfarin and may become an alternative treatment.

Comment: A must read from the *BMJ*.

25-088 Statin therapy, LDL cholesterol, c-reactive protein, and coronary artery disease.

Nissen SE, Tuzcu EM, Schoenhagen P, et al. N Engl J Med. 6 January 2005. Vol.352. No.1. p.29-38.

Reviewed by Dr Ross McCormick

Review: Recent trials have demonstrated better outcomes with intensive rather than with moderate statin treatment. Intensive treatment produced greater reductions in both low-density lipoprotein (LDL), cholesterol and C-reactive protein (CRP), suggesting a relationship between these two biomarkers and disease progression. The authors performed intravascular ultrasonography in 502 patients with angiographically documented coronary disease. Patients were randomly assigned to receive moderate treatment (40mg of pravastatin orally per day) or intensive treatment (80mg of atorvastatin orally per day). Ultrasonography was repeated after 18 months to measure the progression of atherosclerosis. The study showed a reduced rate of progression of atherosclerosis associated with intensive statin treatment, as compared with moderate statin treatment for patients with coronary artery disease, and this reduced rate is significantly related to greater reductions in the levels of both atherogenic lipoproteins and CRP.

Comment: The moral of this article appears to be that it is better to treat aggressively with statins rather than gently.

Cerebrovascular System

25-089 Clinical diagnosis of patients with cerebrovascular disease.

Caplan LR, Hon FK. Prim Care. March 2004. Vol.31. No.1. p.95-109.
Reviewed by Dr M Hewitt
Review: The major consideration for best care and management involves accurate and timely clinical diagnosis. It then follows that the best care and outcome can be obtained from this careful collection of the base data.
Comment: For ambulatory patients, those diagnostic support facilities with ease of access make for superior care. The question as always is the level of funding and who pays for what.

25-090 Homocysteine and stroke.

Hankey GJ, Eikelboom JW. Lancet. 15 January 2005. Vol.365. No.9455. p.194-6.
Reviewed by Dr Tony Hanne
Review: This is a commentary, on a very technical article in the same issue, examining the importance of high homocysteine levels in the incidence of stroke. Using a genetic marker the researchers appeared to show a correlation. Levels of homocysteine can be lowered by taking folic acid, B6 or B12 but there is as yet no evidence that taking these vitamins for this purpose is actually reducing the risk of stroke. In fact their use may bring other problems.
Comment: It is still by no means clear that knowing about homocysteine levels is useful other than as another way of making patients anxious about a risk they cannot change, and of keeping laboratories in business with an expensive test, but time and more research may alter this. (See also 25-091).

25-091 Homocysteine and stroke: evidence on a causal link from mendelian randomisation.

Casas JP, Bautista LE, Smeeth L, et al. Lancet. 15 January 2005. Vol.365. No.9455. p.224-32.
Reviewed by Dr Tony Hanne
Review: See 25-090.

Contraception and Family Planning

25-092 Direct access to emergency contraception through pharmacies and effect on unintended pregnancy and STIs: a randomized controlled trial.

Raine TR, Harper CC, Rocca CH, et al. JAMA. 5 Jan 2005. Vol.293. No.1. p.54-62.
Reviewed by Dr Ross McCormick
Review: This paper reports a randomised, single-blind, controlled trial of 2117 women, ages 15 to 24 years, attending California clinics providing family planning services. Participants were assigned to one of the following groups: pharmacy access to EC; advance provision of three packs of levonorgestrel EC; or clinic access (control). Primary outcomes were use of EC, pregnancies, and sexually transmitted infections (STIs) assessed at six months. Compared with controls, women in the pharmacy access and advance provision groups did not experience a significant reduction in pregnancy rate or increase in STIs. There were no differences in patterns of contraceptive or condom use or sexual behaviours by the study group. Women in the pharmacy access group were no more likely to use EC (24.2%) than controls (21.0%) (P=.25). Women in the advance provision group (37.4%) were almost twice as likely to use EC than controls (21.0%) (P<.001).
Comment: An interesting and thought provoking study. What do these types of studies mean for general practice? (see also Editorial 25-093).

25-093 Placing emergency contraception in the hands of women.

Litt IF. JAMA. 5 January 2005. Vol.293. No.1. p.98-9.
Reviewed by Dr Ross McCormick
Review: See 25-092.

Dermatology

25-094 First- or second-generation antihistamines: which are more effective at controlling pruritus?

Crownover BK, Jamieson B. J Fam Pract. September 2004. Vol.53. No.9. p.742-4.
Reviewed by Dr Bruce Adlam
Review: For urticarial itch, first- and second-generation antihistamines have similar clinical benefit and are superior to placebo (SOR: A). For itch related to atopic dermatitis, antihistamines are no better than placebo (SOR: B).

25-095 Randomised controlled trial of intravenous antibiotic treatment for cellulitis at home compared with hospital.

Corwin P, Toop L, McGeoch G, et al. BMJ. 15 January 2005. Vol.330. No.7483. p.129-32.

Reviewed by Dr Len Brake

Review: Home treatment for cellulitis is about half the cost of hospital based treatment. This Christchurch based study with 200 patients in a RCT demonstrates that IV antibiotic treatment can be safely and effectively administered in the patient's home and needless to say patients prefer the home treatment.

25-096 Approach to skin ulcers in older patients.

Frank C. Can Fam Physician Med Fam Can. December 2004. Vol.50. p.1653-9.

Reviewed by Dr Mike Lyons

Review: Broad evidenced review of skin ulcer assessment and management principles. Although we may have heard most of it before, timely reminders are always appropriate. Succinct with tables of ulcer staging, differential diagnosis, factors affecting wound healing and dressing options with germane comments.

Comment: Good article for doctor/practice nurse collaborative education. Did you know diabetic patients can have falsely elevated ankle-brachial index readings?

Diagnosis

25-097 Analysis of air contrast barium enema, computed tomographic colonography, and colonoscopy: prospective comparison.

Rockey DC, Paulson E, Niedzwiecki D, et al. Lancet. 22 January 2005. Vol.365. No.9456. p.305-11.

Reviewed by Dr Tony Hanne

Review: In a study of 614 patients at high risk of colon cancer, colonoscopy proved to be markedly superior to CTC and ACBE particularly for smaller lesions. Patients favour CTC because it is non-invasive, much cheaper and therefore more readily available. If reliable it could be a way of making colon cancer screening for those at risk affordable in the public system.

Comment: Experienced radiologists argue that in their hands CTC is virtually as good as colonoscopy for the lesion greater than 10mm which are clinically the ones which are urgent. Technique and experience will probably improve the dependability of CTC but for the moment colonoscopy remains the gold standard.

Ear, Nose and Throat

25-098 What is the most effective diagnostic evaluation of streptococcal pharyngitis?

Merrill B, Kelsberg G, Jankowski TA. J Fam Pract. September 2004. Vol.53. No.9. p.734, 37-8, 40.

Reviewed by Dr Bruce Adlam

Review: Standardised clinical decision rules, such as the Centor criteria, can identify patients with low likelihood of group A beta-hemolytic streptococcal pharyngitis, who require no further evaluation or antibiotics (SOR: A). For patients at intermediate and higher risk by clinical prediction rules, a positive rapid antigen detection test is highly specific (SOR: A). Expert opinion suggests adding a back-up throat culture in children and populations with an increased prevalence of streptococcal complications.

Comment: The 4 Centor criteria (history of fever, anterior cervical adenopathy, tonsillar exudates, absence of cough) are well validated in adult populations (in US) while McIssac are validated in populations with children and adults (in US).

25-099 10-minute consultation: Tinnitus.

Hannan SA, Sami F, Wareing MJ. BMJ. 29 January 2005. Vol.330. No.7485. p.237.

Reviewed by Dr Len Brake

Review: Another in the series ideal for the plastic folder at the surgery.

Comment: I fill this folder with the 10 minute consultations. Ideal for reviewing patients with the trainee interns plus a good reminder for the ageing GP mind.

Endocrinology

25-100 Preventing foot ulcers in patients with diabetes.

Singh N, Armstrong DG, Lipsky BA. JAMA. 12 January 2005. Vol.293. No.2. p.217-28.

Reviewed by Dr Ross McCormick

Review: Among persons diagnosed as having diabetes mellitus, the prevalence of foot ulcers is 4% to 10%, and the lifetime incidence may be as high as 25%. This article systematically reviews the evidence of the efficacy of methods advocated for preventing diabetic foot ulcers in the primary care setting. Educating patients about proper foot care and periodic foot examinations are emphasised, as are optimising glycemic control, smoking cessation, intensive podiatric care, debridement of calluses, and certain types of prophylactic foot surgery.

Comment: A well written review of the evidence. The article comments that prevention of diabetic foot ulcers begins with screening for loss of protective sensation, which is best accomplished in the primary care setting with a brief history and the use of a monofilament sensation tester. (Patient Page attached).

25-101 Insulin analogues.

Hirsch IB. N Engl J Med. 13 January 2005. Vol.352. No.2. p.174-83.

Reviewed by Dr Ross McCormick

Review: Since the 1990s there has been renewed interest in producing safer insulin formulations that more closely duplicate the basal and mealtime components of endogenous insulin secretion. This interest has yielded insulin analogues that are characterised by action profiles that afford more flexible treatment regimens with a lower risk of the development of hypoglycemia. This article examines the use of these newer insulins in clinical practice.

Comment: An interesting overview. Worth reading just to refresh your-

self on the concepts underpinning modern insulin treatment regimes.

Gastroenterology

25–102 Favorable response to proton pump inhibitors doesn't necessarily diagnose GERD.

J Fam Pract. September 2004. Vol.53. No.9. p.688.
Reviewed by Dr Bruce Adlam
Review: Interesting POEM that claims response to treatment with a proton pump inhibitor does not identify patients as having gastroesophageal reflux disease. As a result, an initial response does not mean patients should remain on long-term treatment. (Original article reviewed: Ann Intern Med 2004; 140: 518-27)
Comment: This supports other research that shows patients can use short-term treatment (two weeks), stop treatment, and then begin treatment again if symptoms recur, which won't happen in approximately half of them (BMJ 1999; 318: 502-7).

25–103 Is the long-term use of proton pump inhibitors safe?

Malaty W, Stigleman S, Mayer J. J Fam Pract. September 2004. Vol.53. No.9. p.740-2.
Reviewed by Dr Bruce Adlam
Review: Long-term use of proton pump inhibitors (PPIs) appears safe, resulting in no clinically relevant adverse effects (SOR: B). No evidence clearly links PPIs to gastric cancer or carcinoid, enteric infections, or significant nutrient malabsorption. One cohort study and one randomised controlled trial of patients taking omeprazole from one to four years showed no association between PPI use and atrophic gastritis. The same review reported that another cohort study of patients using omeprazole for one year showed an increase in atrophic gastritis. None of the studies reviewed showed an association between omeprazole use and intestinal metaplasia or its progression to gastric adenocarcinoma.
Comment: Four years' use of PPI use may not be long enough to assume PPI safety with regard to atrophic gastritis or gastric cancer.

25–104 Biliary pain.

Mackay S, Dillane P. Aust Fam Physician. December 2004. Vol.33. No.12. p.977-81.
Reviewed by Dr Rachel Monk
Review: The main focus of this article is biliary colic and its differentials. The article illustrates that though a typical presentation of biliary colic is easy to diagnose, presentations are not always clear cut and differential diagnoses have to be considered.

25–105 Colonic diverticular disease.

Steel M. Aust Fam Physician. December 2004. Vol.33. No.12. p.983-6.
Reviewed by Dr Rachel Monk
Review: Good discussion on diverticulosis and diverticulitis and their current management, with cases to illustrate.
Comment: Common problem – nice summary.

25–106 Gastro-oesophageal reflux disease: current concepts in management.

Piterman L, Nelson M, Dent J. Aust Fam Physician. December 2004. Vol.33. No.12. p.987-91.
Reviewed by Dr Rachel Monk
Review: Nice article with updated information on diagnosis and management of gastro-oesophageal reflux disease (GORD). The emphasis is that GORD is primarily a clinical diagnosis and endoscopy should be reserved for when there are alarm symptoms. From a pharmacological point of view the main advance is a focus on a 'step down', rather than the traditional 'step up', approach.

Geriatrics

25–107 Elder abuse.

Kurrie S. Aust Fam Physician. October 2004. Vol.33. No.10. p.807-12.
Reviewed by Dr Rachel Monk
Review: This article defines elder abuse well and goes beyond only physical harm. There are three cases to help illustrate the topic and a discussion on how to assess for abuse as well as appropriate interventions.
Comment: Good reminder that this is a problem which needs to be considered when consulting with older people – especially those with a variety of problems.

25–108 Advance care planning and end of life decision making.

Cartwright CM, Parker MH. Aust Fam Physician. October 2004. Vol.33. No.10. p.815-8.
Reviewed by Dr Rachel Monk
Review: Brief discussion of the issues involved in planning end of life decisions including some information on enduring power of attorney and how to decide whether a patient has the capacity to make decisions.

Gynaecology

25–109 Many unnecessary Pap smears are performed after hysterectomy.

J Fam Pract. September 2004. Vol.53. No.9. p.682, 85.
Reviewed by Dr Bruce Adlam
Review: This study suggests that in the US the cervical smear rate before and after its 20 million hysterectomies since 1996 does not change significantly. Based on the assumption a maximum half would have had hysterectomy for cervical abnormalities then 10 million continue to be screened unnecessarily. (Original article reviewed: JAMA 2004; 291:2990-3)

25–110 Do we need to treat vulvovaginitis in prepubertal girls?

Joishy M, Ashtekar CS, Jain A, et al. BMJ. 22 January 2004. Vol.330. No.7484. p.186-8.
Reviewed by Dr Len Brake
Review: Vulvovaginitis is the commonest gynaecological problem in younger girls. The low oestrogen levels make the vaginal mucosa susceptible to infection. Vaginal microflora has not been well studied in normal girls making it difficult to decide

whether swab results truly indicate the cause of a vaginitis.
Comment: Treatments are looked at with a reminder that discovery of an organism associated with sexual transmission calls for careful evaluation for sexual abuse.

25–111 Assessment of women in midlife.

Reddish S. Aust Fam Physician. November 2004. Vol.33. No.11. p.883-7.
Reviewed by Dr Rachel Monk
Review: Midlife is not just about 'hormones'. Women will present for a large number of reasons. GPs need to be systematic in their approach and explore multiple areas, which may contribute, to the presenting problem(s). History is exceptionally important.
Comment: I found this article very helpful. A good reminder of the temptation to attribute many midlife symptoms to hormonal changes, and encouragement to avoid falling into this trap.

25–112 Dysfunctional uterine bleeding.

Farrell E. Aust Fam Physician. November 2004. Vol.33. No.11. p.906-8.
Reviewed by Dr Rachel Monk
Review: Useful discussion on the diagnosis and management of dysfunctional uterine bleeding, which is a common problem amongst reproductive women. The main focus is on medical treatments but surgical options are also briefly discussed.

25–113 Chronic pelvic pain in women: assessment and management.

Dick M-L. Aust Fam Physician. December 2004. Vol.33. No.12. p.971-6.
Reviewed by Dr Rachel Monk
Review: Chronic pelvic pain can pose a diagnostic dilemma due to the many possible diagnoses. This article focuses predominantly on the common causes: endometriosis, pelvic inflammatory disease and irritable bowel syndrome.
Comment: There is also an interesting case, which illustrates how complex this area can be.

Immunology and Allergy

25–114 Immunity's early-warning system.

O'Neill LA. Sci Am. January 2005. Vol.292. No.1. p.38-45.
Reviewed by Dr Ron Vautier
Review: The innate immune system responds to foreign material regardless of whether it has been encountered before or not. This response occurs when the foreign proteins bind to Toll-like receptors, which leads to the production of cytokines which then activate B and T cells of the adaptive response.
Comment: This article explains and illustrates the subject clearly and therefore is definitely recommended.

Metabolic Diseases

25–115 Adiposity as compared with physical activity in predicting mortality among women.

Hu FB, Willett WC, Li T, et al. N Engl J Med. 23 December 2004. Vol.351. No.26. p.2694-703.
Reviewed by Dr Ross McCormick
Review: The authors examined the associations of body-mass index and physical activity with death among 116 564 women who, in 1976, were 30 to 55 years of age and free of known cardiovascular disease and cancer. Mortality rates increased over 24 years of follow-up with higher body-mass-index values among women who had never smoked. Higher levels of physical activity appeared to be beneficial at all levels of adiposity but did not eliminate the higher risk of death associated with obesity. The authors estimate that excess weight (defined as a body-mass index of 25 or higher) and physical inactivity (less than 3.5 hours of exercise per week) together could account for 31 per cent of all premature deaths, 59 per cent of deaths from cardiovascular disease, and 21 per cent of deaths from cancer among nonsmoking women.
Comment: A useful article to read. It is of course a study of American women, but it confirms our clinical opinion. Patients who ask for more evidence about why you want them to alter their lifestyle might find it of value.

Musculoskeletal System

25–116 Effect of arthrographic shoulder joint distension with saline and corticosteroid for adhesive capsulitis.

Buchbinder R, Green S. Br J Sports Med. August 2004. Vol.38. No.4. p.384-5.
Reviewed by Dr Chris Milne
Review: Frozen shoulder is a disabling condition which typically takes up to two years to resolve. This study of 93 people showed that a single intra-articular injection of corticosteroid under fluoroscopic guidance combined with a simple home exercise was significantly better than placebo at improving pain and disability, especially in the first three months after symptoms developed.
Comment: These authors used significant volumes of injection material (mean volume 43ml). This study confirms the advice given in the recently published NZ shoulder guidelines.

25–117 Nonsurgical treatment is effective for carpal tunnel syndrome.

J Fam Pract. September 2004. Vol.53. No.9. p.685.
Reviewed by Dr Bruce Adlam
Review: This systematic review by our own Bruce Arroll and Felicity Goodyear-Smith, claims nonsurgical treatments of carpal tunnel syndrome, using injected or oral steroids, provides temporary relief and spontaneous resolution is common. Fifty per cent of patients receiving placebos improved. (Original article reviewed: Ann Fam Med 2004; 2: 267-73)
Comment: The authors were unable to find support for the use of nonsteroidal anti-inflammatory drugs, chiropractic manipulation, pyridoxine, diuretics, or magnets.

25–118 Resting injured limbs delays recovery: A systematic review.

Nash CE, Mickan SM, Del Mar CB, et al. J Fam Pract. September 2004. Vol.53. No.9. p.706-12.
Reviewed by Dr Bruce Adlam

Review: Injured limbs are traditionally rested by splint or cast. This is undertaken both for palliation and also in the belief that resting improves recovery time, and reduces complications such as deformity, functional problems and long-term pain. The recommendations that emerge from this systematic review suggest: (1) Early mobilisation decreases pain, swelling and stiffness, particularly in the short term, without longer-term cosmetic or radiologic deformity. (SOR: A); (2) Patients usually prefer early mobilisation, and return to work earlier. (SOR: C); (3) Rest may be overused for limb injuries (SOR: C). More trials are needed to identify optimal programmes for early mobilisation.

Comment: Well written article with an excellent list of references covering a wide spectrum of injuries.

25-119 Dispelling the myths about ankylosing spondylitis.

Schachna L. Intern Med J. November 2004. Vol.34. No.11. p.591-3.
Reviewed by Dr Helen Moriarty

Review: A short but well-written article that examines the evidence surrounding common medical (mis)-constructions about ankylosing spondylitis.

Comment: One such new approach is the use of bisphosphonates. Although available in NZ currently, there are restrictions on patient eligibility which may need to be addressed to include such indications as ankylosing spondylitis.

25-120 Effect of acupuncture treatment on chronic neck and shoulder pain in sedentary female workers: a 6-month and 3-year follow-up study.

He D, Veiersted KB, Hostmark AT, et al. Pain. June 2004. Vol.109. No.3. p.299-307.
Reviewed by Dr Alex Chan

Review: The study examined the short and long-term effects of a combination of manual and electro-acupuncture (EA) plus ear acupressure on chronic neck and shoulder pain and related headaches in 24 female office workers. Real acupuncture points were used in the treatment group versus sham acupuncture points in the control group. While the needles were connected to an electro-acupuncture instrument, in the control group only noise signals without voltage were given. It was found that compared with the control group, the treatment group experienced significantly less pain, both in intensity and frequency, and less headaches during as well as three years after the treatment period. The pain threshold of some muscles also rose in the treatment group during the treatments and remained higher six months later.

Comment: Six ear points were used – Shenmen, Neck, Cervical spine, Shoulder, Shoulder joint, Shoulder (back). The subjects were instructed to press on each of the ear acupoints four times per day 100 times each time. Together with the manual and EA, this represented a very intensive regime but with good results.

25-121 Does this woman have osteoporosis?

Green AD, Colon-Emeric CS, Bastian L, et al. JAMA. 15 December 2004. Vol.292. No.23. p.2890-900.
Reviewed by Dr Ross McCormick

Review: Identifying women at increased risk for osteoporosis and women with occult vertebral fractures remains a clinical challenge. The evidence is reviewed around the accuracy and precision of physical examination findings for the diagnosis of osteopenia, osteoporosis, or spinal fracture. No single manoeuvre is sufficient to rule in or rule out osteoporosis or spinal fracture without further testing. The following yielded the greatest positive likelihood ratios (LR+): weight less than 51kg, LR+, 7.3 (95% confidence interval [CI], 5.010.8); tooth count less than 20, LR+, 3.4 (95% CI, 1.4-8.0); rib-pelvis distance less than two finger breadths, LR+, 3.8 (95% CI, 2.9-5.1); wall-occiput distance greater than 0 cm, LR+, 4.6 (95% CI, 2.9-7.3), and self-reported humped back, LR+, 3.0 (95% CI, 2.2-4.1).

Comment: An interesting review. Several convenient examination manoeuvres, especially low weight, can significantly change the pretest probability of osteoporosis and suggests the need for earlier screening. Wall-occiput distance greater than 0cm and rib-pelvis distance less than two fingerbreadths suggest the presence of occult spinal fracture.

25-122 Shoulder pain and weakness.

Kelly JD. Physician and Sportsmedicine. November 2004. Vol.32. No.11. p.19-23.
Reviewed by Dr Rob Campbell

Review: A clinical case report of a patient presenting with shoulder pain and weakness. It explores the physical symptoms, signs, investigation and management of an isolated subscapularis tear.

Comment: The main value of this article is the demonstration with photos of the tests for the subscapularis muscle tendon unit.

25-123 Plantar fasciitis: Current concepts to expedite healing.

Glazer JL, Brukner P. Physician and Sportsmedicine. November 2004. Vol.32. No.11. p.24-8.
Reviewed by Dr Rob Campbell

Review: A review of current concepts of managing this condition. Attention to biomechanical factors and stimulating healing are the main focus points of this paper.

Comment: An excellent up-to-date review of this frustrating degenerative condition.

Neurology

25-124 The postconcussion syndrome and whiplash injuries: a question-and-answer review for primary care physicians.

Evans RW. Prim Care. March 2004. Vol.31. No.1. p.1-17.
Reviewed by Dr M Hewitt

Review: The author uses a question and answer format to review post-concussion syndrome and whiplash injuries. The concussion guidelines mentioned are those in use for professionals in contact sports.
Comment: These are common presentations for assessment for GPs as well as Accident and Medical Practitioners.

25–125 Neck pain.

Devereaux MW. Prim Care. March 2004. Vol.31. No.1. p.19-31.
Reviewed by Dr M Hewitt
Review: A look at a common presenting condition. Important features of the neurological examination are mentioned. Some treatment modalities, such as neck manipulation are cautioned advisedly.
Comment: Although not as common as low back pain, a worthwhile review by ACC through its education programme would be worthwhile.

25–126 Low back pain.

Devereaux MW. Prim Care. March 2004. Vol.31. No.1. p.33-51.
Reviewed by Dr M Hewitt
Review: A good review of the condition with essential features of the neurological examination described. The need to determine the serious from the mundane is also discussed, with a view to when to proceed with expensive investigations and specialist referral.
Comment: A refinement of the ACC 'Low Back Pain' management and guidelines. Very similar in the 'red flag and yellow flag' conditions outlined.

25–127 Entrapment neuropathies.

Younger DS. Prim Care. March 2004. Vol.31. No.1. p.53-65.
Reviewed by Dr M Hewitt
Review: A good description of the common entrapment syndromes encountered by the Primary Care physician, with detail regarding appropriate examination and history. Knowledge of the anatomy helps to diagnose associated vasculation complications.
Comment: As with most things in medical practice, a good history and examination often reduces the need for further expensive imaging and diagnostic procedures to obtain the correct diagnosis.

25–128 Peripheral nerve disorders.

Younger DS. Prim Care. March 2004. Vol.31. No.1. p.67-83.
Reviewed by Dr M Hewitt
Review: A good look at recent improvements in clinical assessment of neuropathies. In particular the range of electro-mechanical enhancements and imaging techniques for superior diagnostic information. The biochemists and histopathologists have also made significant diagnostic advances and these are described and discussed.

25–129 Seizure disorders.

Schachter SC. Prim Care. March 2004. Vol.31. No.1. p.85-94.
Reviewed by Dr M Hewitt
Review: A thorough analysis of the necessary work required for diagnosis and management of epilepsy. The differential diagnosis is an important consideration. Once this is done, then the follow-up and education, and risk management of this chronic health disorder is good primary care.

25–130 Movement disorders.

Minagar A, Kelley RE. Prim Care. March 2004. Vol.31. No.1. p.111-127.
Reviewed by Dr M Hewitt
Review: Rare and severe, common and benign movement disorders are discussed and described along with diagnostic considerations, and management and treatment protocols.
Comment: Even the rare disorders are common.

25–131 Memory complaints and dementia.

Kelley RE, Minagar A. Prim Care. March 2004. Vol.31. No.1. p.129-148.
Reviewed by Dr M Hewitt
Review: The authors describe and distinguish between natural processes of loss of function, and disease processes which accelerate the loss of function of memory and cognition.
Comment: More common, given an ageing population.

25–132 A discussion of sleep.

Olejniczak PW, McGuire SM, Fisch BJ. Prim Care. March 2004. Vol.31. No.1. p.149-74.
Reviewed by Dr M Hewitt
Review: One of the more common complaints presenting to primary care physicians and one with relatively little known about it. The authors discuss the patterns of sleep disorder in terms of clinical manifestations and available diagnosis facilities to determine best management.
Comment: An improvement over the simple prescription of a hypnosedative.

25–133 Syncope and orthostatic intolerance for the primary care physician.

Weimer LH. Prim Care. March 2004. Vol.31. No.1. p.175-99.
Reviewed by Dr M Hewitt
Review: Fits, faints, black outs and giddy spells are more common in the older age group due to cerebrovascular pathology. In all age groups, wider consideration must be given to rare causes of the presenting manifestation. Recommendations for treatment and best management depend on accurate diagnosis.

25–134 Multiple sclerosis.

Hawker K, Frohman E. Prim Care. March 2004. Vol.31. No.1. p.201-26.
Reviewed by Dr M Hewitt
Review: This common but serious neurological disorder is among the most common causes of disability in young people. The autoimmune aetiology of this disorder is still not clear and there is no appropriate effective treatment.
Comment: Some funding is available on specialist recommendation for interferon, but the product is prohibitively expensive.

25–135 The brain's own marijuana.

Nicoll RA, Alger BE. Sci Am. December 2004. Vol.291. No.6. p.69-75.
Reviewed by Dr Ron Vautier
Review: Two endocannabinoids, anandamide and 2-AG, are identi-

fied, and receptors for them are located in several parts of the brain and spinal cord, and the immune system. 2-AG is important in retrograde synaptic signal transmission, especially at GABA releasing neurons.
Comment: Regulation of endocannabinoid activity could lead to new pharmaceuticals to treat anxiety, pain, nausea, other neurological disorders, and control appetite.

25–136 Epidemiology and impact of headache: an overview.
Smith TR. Prim Care. June 2004. Vol.31. No.2. p.237-41.
Reviewed by Dr M Hewitt
Review: A frequent and common malady, afflicting all of humankind in one form or another. It is as much a symptom as a diagnosis and the author looks at the broad aspects of this presenting complaint.
Comment: Take aspirin.

25–137 Diagnosis and classification of headache.
Taylor FR. Prim Care. June 2004. Vol.31. No.2. p.243-59.
Reviewed by Dr M Hewitt
Review: The author uses a screening technique to enable the primary care physician to make a diagnosis. He feels that migraine, in particular, is often overlooked and, therefore, underdiagnosed and treated.
Comment: A single, nice, easy to follow questionnaire.

25–138 The pathophysiology of primary headache.
Schreiber CP. Prim Care. June 2004. Vol.31. No.2. p.261-76.
Reviewed by Dr M Hewitt
Review: Reviews and describes the various factors responsible for the manifestation of headache. In particular, gross and neuro anatomy, with attention to vascular supply, and the neuroendocrine and neurovascular triggers which research indicates are involved in primary headache production.
Comment: Not too detailed and an easy read.

25–139 Migraine diagnosis and treatment.
Loder E. Prim Care. June 2004. Vol.31. No.2. p.277-92.
Reviewed by Dr M Hewitt
Review: Documents and describes a well researched condition. The author gives appropriate weighting to clinical diagnosis as well as up to date treatment. She also includes guideline algorithms for interventions.
Comment: A good summary of the distinction between migraine with aura and without aura. This distinction has implications for successful interventions.

25–140 Tension-type headaches: what they are and how to treat them.
Krusz JC. Prim Care. June 2004. Vol.31. No.2. p.293-312.
Reviewed by Dr M Hewitt
Review: The article discusses the clinical distinctions between tension-type headaches and migraine. It concludes that the evidence for distinction is not strong, and that the two entities may be part of a spectrum of the same disorder.
Comment: This has implications for successful clinical treatment and management.

25–141 Cluster headache.
Freitag FG. Prim Care. June 2004. Vol.31. No.2. p.313-29.
Reviewed by Dr M Hewitt
Review: These previously uncommon types of headaches and their clinical characteristics are discussed.
Comment: Recent advances in understanding the aetiology have resulted in improved therapeutic responses and better overall management outcomes.

25–142 Miscellaneous primary headache.
Wheeler SD. Prim Care. June 2004. Vol.31. No.2. p.331-51.
Reviewed by Dr M Hewitt
Review: Of all the many types of headache that could be included in the above category, the author has chosen to discuss, in depth, two types. One, being those headaches derived from the trigeminal cranial nerve and the other being those without dysfunction involving the autonomic nerves.

25–143 Chronic daily headache.
Hutchinson S. Prim Care. June 2004. Vol.31. No.2. p.353-67.
Reviewed by Dr M Hewitt
Review: The author is aware of the difficulty in regard to the diagnosis of this particular descriptive condition. The use of a methodical pattern of analysis is provided to assist in arriving at the correct diagnosis.
Comment: The aim being to improve management, and, hence, outcome.

25–144 Medication overuse headache.
Ward TN. Prim Care. June 2004. Vol.31. No.2. p.369-80.
Reviewed by Dr M Hewitt
Review: Frequently these types of headache occur in known chronic headache sufferers who are already using medication. The author describes the 'rebound' phenomenon which causes headaches in this group. Outside of this group are all those regular users of medication, prescribed or otherwise, who develop the complication or accompaniment of headache. The diagnosis, treatment and management of this group is self-evident, providing the correct diagnosis is made in the first place.

25–145 Secondary headache and head pain emergencies.
Peters KS. Prim Care. June 2004. Vol.31. No.2. p.381-93.
Reviewed by Dr M Hewitt
Review: Describes that group of patients whose headache is secondary to organic lesions, vascular or space-occupying. The presentation and description help to familiarise this important diagnosis for the primary care physician.
Comment: The condition could be life-threatening and a prompt consideration of the differential diagnosis can be life-saving.

25–146 Common headache misdiagnoses.

Ryan RE, Pearlman SH. Prim Care. June 2004. Vol.31. No.2. p.395-405.
Reviewed by Dr M Hewitt
Review: The authors review the prevalence of headache types when diagnosed at the doctor's rooms. The odds are high that these will be primary headaches (90%) and of these, tension and migraine are most common. The authors have a good series of lists of warnings to alert the doctor to atypical headaches, usually secondary, resulting from a specific clinical disorder.
Comment: The key to the correct diagnosis is, as always, a carefully taken history. The authors provide a good template for this.

25-147 Managing migraine in children and adolescents.

Pearlman EM. Prim Care. June 2004. Vol.31. No.2. p.407-15.
Reviewed by Dr M Hewitt
Review: The author recognises that this condition is often overlooked and, hence, mistreated in the younger age group. A reminder of the prevalence as well as the diagnostic presentation will facilitate correct diagnosis. Special features of migraine presentation in children are discussed.

25-148 Headache in women.

Johnson CJ. Prim Care. June 2004. Vol.31. No.2. p.417-28.
Reviewed by Dr M Hewitt
Review: Headaches in women are more prevalent than men, and migraine, in particular, has three times the frequency. Causes and specific factors relating to women are hormonally based. The specific part hormones play in migraine triggers is discussed.
Comment: It's a hormone thing.

25-149 Challenging or difficult headache patients.

Landy SH. Prim Care. June 2004. Vol.31. No.2. p.429-40.
Reviewed by Dr M Hewitt
Review: Migraine is the most commonly misdiagnosed condition because its presentation can be atypical. The next group of commonly untreated headaches belong in the secondary headache category. Finally, the last group are the correctly diagnosed who do not respond to conventional treatment.
Comment: Something different for everyone.

Nutrition

25-150 Effects of moderate consumption of white wine on weight loss in overweight and obese subjects.

Flechtner-Mors M, Biesalski HK, Jenkinson CP, et al. Int J Obes. December 2004. Vol.28. No.11. p.1420-6.
Reviewed by Dr Anne-Thea McGill
Review: This study looked at 40 obese people who habitually drank modest alcohol. Twenty undertook a weight loss diet with 200ml white wine and 20 (controls) with 200mls grape juice a day for three months. The diet was an energy deficit diet of 2.1-2.9 MJ (500-700 kcal) which had 10% of energy as grape juice or white wine. The white wine drinkers lost non-significant more weight, and both groups lost 3.75-4.75kg weight. Drinking modest white wine regularly can be allowed on weight loss programmes.
Comment: This timely and well controlled study reinforces evidence that alcohol (not just the other wine elements like phenols) can be taken in weight loss. It can be drunk with weight loss programmes and not be prescribed as is often the case. Alcohol can slow the progression to diabetes and is associated with less CVD. Weight loss needs to be made as easy and pleasant as possible as it is hard in our environment. This article does add that only white wine has been included in the study – however I think as other studies on alcohol metabolism in obesity bear out the findings it is probably fair to include other alcohol sources.

25-151 Flow-resistant red blood cell aggregation in morbid obesity.

Samocha-Bonet D, Ben-Ami R, Shapria I, et al. Int J Obes. December 2004. Vol.28. No.12. p.1528-34.
Reviewed by Dr Anne-Thea McGill
Review: This paper, technical, but clear to read, shows how RBC aggregation (size of cell clumps and resistance to dispersion) and hence ESR, is causally related to increased plasma inflammatory proteins (e.g. fibrinogen, CRP and IgG) as seen in obesity. This occurs even before conditions known to promote clotting, such as Type II Diabetes (TIIDM) and CVD, supervene.
Comment: Have you wondered at the high ESR in obese persons and believed in was 'skin chaffing' as I was told. This paper gives a cogent explanation of the significance of the rise in the ESR seen in the obese and those with large waist girth. This information should prompt clinicians to assess other markers of inflammation and CVD risk factors in those with the metabolic syndrome, advise on lifestyle changes, start relevant medication and monitor over time to prevent TIIDM and atherothromobotic CVD events.

25-152 Meat consumption and risk of colorectal cancer.

Chao A, Thun MJ, Connell CJ, et al. JAMA. 12 January 2005. Vol.293. No.2. p.172-82.
Reviewed by Dr Ross McCormick
Review: The article examines the relationship between recent and long-term meat consumption and the relative risk of colon and rectal cancer by examining data from a USA cohort of 148 610 adults aged 50 to 74 years who provided information on meat consumption in 1982, and again in 1992/1993, when enrolled in a Cancer Prevention Study II. High intake of red and processed meat reported in 1992/1993 was associated with higher risk of colon cancer after adjusting for age and energy intake but not after further adjustment for body mass index, cigarette smoking, and other covariates.
Comment: This article is only relevant because your patients may find

it on the Internet and ask you about it. The authors report their results in terms of relative risk rather than absolute risk, which make their results appear more clinically significant than they really are. It also appears that socioeconomic and other behavioural factors may have influenced and perhaps biased some of their reported findings. (see also 25-153 and 25-154).

25–153 Consumption of vegetables and fruits and risk of breast cancer.

van Gils CH, Peeters PH, Bueno-de-Mesquita HB, et al. JAMA. 12 January 2005. Vol.293. No.2. p.183-93.

Reviewed by Dr Ross McCormick

Review: See 25-152 and 25-154.

25–154 Diet and cancer: an evolving picture.

Willett WC. JAMA. 12 January 2005. Vol.293. No.2. p.233-4.

Reviewed by Dr Ross McCormick

Review: See 25-152 and 25-153.

Oncology

25–155 Risk of fracture after androgen deprivation for prostate cancer.

Shahinian VB, Kuo Y-F, Freeman JL, et al. N Engl J Med. 13 January 2005. Vol.352. No.2. p.154-64.

Reviewed by Dr Ross McCormick

Review: The authors studied the records of 50 613 men who were listed in the linked database of the Surveillance, Epidemiology, and End Results program and Medicare as having received a diagnosis of prostate cancer in the period from 1992 through 1997. The primary outcomes were the occurrence of any fracture and the occurrence of a fracture resulting in hospitalisation. Of men surviving at least five years after diagnosis, 19.4 percent of those who received androgen-deprivation therapy had a fracture, as compared with 12.6 percent of those not receiving androgen-deprivation therapy (P<0.001).

Comment: Androgen-deprivation therapy for prostate cancer appears to increase the risk of fracture.

Physician–Patient Relations

25–156 R-E-S-P-E-C-T: Patient reports of disrespect in the health care setting and its impact on care.

Blanchard J, Lurie N. J Fam Pract. September 2004. Vol.53. No.9. p.721-30.

Reviewed by Dr Bruce Adlam

Review: These are givens one would hope, but it's interesting to see this from a different racial mix: (1) Perceptions of disrespect or of receiving unfair treatment within the patient-provider relationship are prevalent, particularly among racial/ethnic minorities; (2) Negative perceptions in the patient-doctor relationship can effect whether a patient follows advice or delays needed care; (3) Therefore, physicians should strive to be respectful and culturally sensitive to the needs of their patients, regardless of ethnic or racial background.

Comment: This study was based on telephone survey of a nationwide random-digit-dial of 6722 adults. An attempt was made to include those for whom English was not their first language. Important groups that were excluded are teens, and those with no access to phone or unable to afford one.

Preventive Medicine and Screening

25–157 Breast cancer mortality in Copenhagen after introduction of mammography screening: cohort study.

Olsen AH, Njor SH, Vejborg I, et al. BMJ. 29 January 2005. Vol.330. No.7485. p.220-2.

Reviewed by Dr Len Brake

Review: This breast screening programme started in 1991. This 10 year evaluation is controlled for regional and historical differences. The 25% reduction in breast cancer mortality indicates that mammography service screening can reduce breast cancer deaths.

Psychiatry and Psychology

25–158 The curious incident of the dog in the night-time.

Ringold S, Fellow F. JAMA. 8 December 2004. Vol.292. No.22. p.2781.

Reviewed by Dr Ross McCormick

Review: Don't read this JAMA review, read the book instead. *The Curious Incident of the Dog in the Night-Time*, by Mark Haddon, 226 pp, with illus, paper, ISBN 1-4000-3271-7, New York. It is available at all bookshops and is one of the recent highlights of my fiction reading list. 'FIND PEOPLE CONFUSING,' writes Christopher John Francis Boone, the 15-year-old boy with probable Asperger disorder who is the fictional author of this novel. Mark Haddon brings a new perspective to a well-publicised but poorly understood disorder.

Comment: Christopher, who is also a mathematical savant, sets out to document his investigation of the murder of a neighbour's dog. What starts as a simple inquiry quickly becomes a much larger journey for Christopher. The suspense in this novel is created less by the investigation of the dog's murder than by the circumstances that force Christopher out of his orderly, planned world into one where even everyday ordinary tasks provoke anxiety. For me the scene where Christopher, accompanied by his pet rat, attempts to find his way through a busy London tube station is one of the highlights of the book. The novel received the Whitbread Book of the Year Award in 2003.

25–159 Diagnosis and management of dementia in general practice.

Pond D, Brodaty H. Aust Fam Physician. October 2004. Vol.33. No.10. p.789-93.

Reviewed by Dr Rachel Monk

Review: Case based article with two GP cases and specialist comments on

diagnosis and management of dementia, including starting and titrating cholinesterase inhibitors. Useful flow chart also on page 791.
Comment: Very common problem in general practice and all would benefit from this, especially from the flow chart.

25-160 Common psychological disorders in childhood.

Ciechomski L, Blashki G, Tonge B. Aust Fam Physician. December 2004. Vol.33. No.12. p.997-1003.
Reviewed by Dr Rachel Monk
Review: Good article covering a difficult area in general practice. Obviously not all conditions can be covered but it is a good overview. Included are some useful questions to ask when school refusal, ADHD or conduct disorder is suspected. We are also reminded that many psychological disorders in childhood will present with somatic complaints, therefore a thorough GP assessment is vital.

25-161 Psychiatry reforms and illegal behaviour of the severely mentally ill.

Schanda H. Lancet. 29 January 2005. Vol.365. No.9457. p.367-9.
Reviewed by Dr Tony Hanne
Review: These two articles need to be read together (see also 25-162). One is a comment on a series of studies, including one from New Zealand, looking at the question of what impact the huge reduction, between 1970 and 2000, of inpatient treatment of psychiatric patients has had on their likelihood of serious offending. The answer is very little. This, obviously, reassures an anxious public. The other is an editorial which questions the huge number of mentally ill people in US prisons. Of the two million people in American prisons, more than 10% are seriously mentally ill. This in turn is three times the number of patients in psychiatric hospitals. Are they being treated in the best place and in the best way, and in fact are they being treated at all?
Comment: Those of us who have a significant number of patients who have been, are, or soon will be in the NZ prison system have asked the same questions about how we manage these problems in this country. There is much argument about where the line should be drawn between treatment and punishment but there should be no dispute about the ultimate goal of effective rehabilitation.

25-162 'The feeble-minded criminal' - 100 years on.

The Lancet. Lancet. 29 January 2005. Vol.365. No.9457. p.359-60.
Reviewed by Dr Tony Hanne
Review: See 25-161.

25-163 Exploding the self-esteem myth.

Baumeister RF, Campbell JD, Kreger JI, et al. Sci Am. January 2005. Vol.292. No.1. p.84-91.
Reviewed by Dr Ron Vautier
Review: Evidence is presented showing that boosting students' self-esteem does not improve their academic performance. Bad behaviour does not correlate with low self-esteem. People with high self-esteem tend to show more initiative and appear to be significantly happier.
Comment: Incidentally, I noted that the correlation of financial satisfaction with overall life satisfaction is especially low in New Zealand.

Public Health

25-164 Choosing health? First choose your philosophy.

McKee M, Raine R. Lancet. 29 January 2005. Vol.365. No.9457. p.369-71.
Reviewed by Dr Tony Hanne
Review: With a great fanfare, after much anticipation, Tony Blair unveiled Britain's latest White Paper on public health. It is similar to New Zealand's attempts in the last few years, by talking about population health rather than individual illness, to persuade the medical profession to convince the public to take responsibility for keeping themselves healthy and so cut the costs of treatment. Apparently when asked to explain his much heralded 'defining philosophy' of health, the British Prime Minister was uncharacteristically lost for words.
Comment: The British government seem to be falling into the same dilemma as has happened in this country. Is public health about encouraging wise choices in relation to health or is it a matter of legislation to enforce those choices? Where is the logic in banning smoking in public places while allowing unhealthy foods to be promoted on television? The health costs of obesity are far greater than those of cigarettes. The decision to legislate or educate should only be made after adequate public debate, hopefully guided by good evidence.

Research Design and Methodology

25-165 Interpretation of survival curves.

Wilson SA. J Fam Pract. September 2004. Vol.53. No.9. p.717.
Reviewed by Dr Bruce Adlam
Review: Useful easy to understand guide on survival curves. Survival curves illustrate prognosis. The percentage of patients reaching an endpoint (e.g. death, recurrence of disease, or cure) is plotted on the y (vertical) axis against time on the x (horizontal) axis.

25-166 Trust and confidence: towards mutual acceptance of ethics committee approval of multicentre studies.

Sarson-Lawrence M, Alt C, Mok MT, et al. Intern Med J. November 2004. Vol.34. No.11. p.598-603.
Reviewed by Dr Helen Moriarty
Review: This was an interesting paper looking at a novel aspect of re-

search – how much the ethical approval delays research efforts. By and large mean approval time via HREC (Australia) was 75 days, and up to 111 days for regions. In only one case did a significant protocol change evolve out of the Ethics Approval process.
Comment: NZ time delays were not this long – but might become so now that HRC has centralised the Ethics Approval process. This is a special disadvantage to GP Researchers who also have to consult the community and Maori too.

Sports and Sports Medicine

25-167 Why we should allow performance enhancing drugs in sport.

Savulescu J, Foddy B, Clayton M. Br J Sports Med. 1 December 2004. Vol.38. No.6. p.666-70.
Reviewed by Dr Chris Milne
Review: These authors argue that there are good reasons to allow everyone to take performance enhancing drugs, provided safety issues can be addressed. For example, doctors should allow people to take EPO (erythropoietin) up to a PCV of 0.5. They state that athletes should be excluded solely on the basis of whether they are healthy enough to compete.
Comment: This is potentially one of the most controversial articles of the year in any scientific journal. The authors challenge the current paradigm in a logical and reasoned manner. Once the media get hold if it, it will be interesting to observe the reaction.

25-168 Blood borne infections in sport: risk of transmission, methods of prevention, and recommendations for hepatitis B vaccination.

Kordi R, Wallace WA. Br J Sports Med. 1 December 2004. Vol.38. No.6. p.678-84.
Reviewed by Dr Chris Milne
Review: Risk of transmission of blood borne infections in sport are virtually nonexistent for HIV, and probably 50–100 times greater for Hepatitis B or C, but still very low in absolute terms. All athletes in collision sports playing at the professional level in New Zealand are screened for Hepatitis B and offered immunisation where appropriate. For Hepatitis C, since there is no vaccine, there are major dilemmas.
Comment: Good review article. The most important lesson from the Magic Johnson case was that his team mates and opponents did not feel comfortable playing with or against him.

25-169 Determining clearance during the preparticipation evaluation.

Boyajian-O'Neill L, Cardone D, Dexter W, et al. Physician and Sportsmedicine. November 2004. Vol.32. No.11. p.29-41.
Reviewed by Dr Rob Campbell
Review: This article explores a number of medical problems which athletes present with and whether they should continue playing. The problems include cardiovascular problems, infections, diabetes, skin problems, disordered eating, eye problems, pregnancy, liver, kidney, spleen, respiratory, epilepsy and other neurological problems.
Comment: A very useful reference article.

25-170 New recommendations for concussion management.

Schnirring L. Physician and Sportsmedicine. December 2004. Vol.32. No.12. p.12-4.
Reviewed by Dr Rob Campbell
Review: A discussion of the place of neuropsychological testing in the diagnosis and management of concussion. Postural stability testing is also discussed as the vestibular mechanisms are disturbed by concussion.
Comment: The gold standard of care is still clinical examination. Some objective help from neuropsychological tests may be useful to support the clinical exam and to educate the patient.

25-171 Cold, wind, and sun exposure: Managing and preventing skin damage.

Snowise M, Dexter WW. Physician and Sportsmedicine. December 2004. Vol.32. No.12. p.26-32.
Reviewed by Dr Rob Campbell
Review: This article explores the various skin damaging conditions seen in outdoor athletes. Frost nip, frostbite, Raynaud's, urticaria and chillblains from cold exposure, and the burns from sun are described.
Comment: A useful article particularly with regard to the cold-related injuries.

25-172 High ankle sprains: minimizing the frustration of a prolonged recovery.

Smith AH, Bach BR. Physician and Sportsmedicine. December 2004. Vol.32. No.12. p.39-43.
Reviewed by Dr Rob Campbell
Review: This article describes the syndesmotic injuries which occur with dorsiflexion and external rotation of the leg. Management is discussed including the need for surgery in Grade III injuries.
Comment: An excellent article with good diagram and x-ray criteria for diagnosis. Special view x-rays may be required.

Surgery

25-173 Augmentation mammoplasty and 'silicone-osis'

Englert H, Joyner E, Thompson M, et al. Intern Med J. December 2004. Vol.34. No.12. p.668-79.
Reviewed by Dr Helen Moriarty
Review: A population retrospective cohort study sought to confirm the existence of 'silicone-osis' due to breast implants. Women who had implants were compared to those with non-silicone-associated plastic surgery in Sydney. Cluster analysis suggests that there is a multisystem disorder associated with silicone implants, but the same symptoms oc-

curred (at lower frequency) in non-exposed participants. The symptoms are: night sweats, lethargy, breast pain, impaired menstruation, reflux, paraesthesiae, myalgia and hand muscle weakness.
Comment: This sounds like the old 'menopause syndrome' in another guise!

Therapeutics

25-174 Correspondence: Discontinuation of Vioxx.

Numerous Correspondents. Lancet. 1 January 2005. Vol.365. No.9453. p.23-8.
Reviewed by Dr Tony Hanne

Review: A couple of issues back the editor of the *Lancet* was highly critical of Merck for taking so long to withdraw Vioxx, despite evidence of higher cardiovascular risk associated with its use. This criticism produced an avalanche of letters to the editor both for and against. Nine of the letters are printed in this issue making up a vigorous, well reasoned debate on the problems associated with research and publication and the need to maintain balance.
Comment: Good debate that depends on evidence and logic rather than rhetoric and abuse is all too rare. The last letter is from a doctor with arthritis who has himself been taking Vioxx, found it wonderful and would happily accept some risk if he were allowed to continue. He represents the patient whose voice is not usually heard.

Virus Diseases

25-175 Are viruses alive?

Villarreal LP. Sci Am. December 2004. Vol.291. No.6. p.101-5.
Reviewed by Dr Ron Vautier

Review: Viruses are parasites that skirt the boundary between life and inert matter. They are fundamentally important players in evolution.
Comment: The question posed is not definitively answered, but it leads into some fascinating insights.

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