Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Am Fam Physician*
Aust Fam Physician*
BMJ*
Br J Sports Med*
Intern Med J*
J Fam Pract*
Lancet*
N Engl J Med*
Obes Res*
Pain*
Physician and Sportsmedicine*
Postgrad Med*
Prim Care*
*Journals indexed in Medline

Acupuncture

25-258 Effects of acupuncture and stabilising exercises as adjunct to standard treatment in pregnant women with pelvic girdle pain: randomised single blind controlled trial.

Elden H, Ladfors L, Oslen MF, et al. BMJ. 2 April 2005. Vol.330. No.7494. p.761-6.
Reviewed by Dr Alex Chan

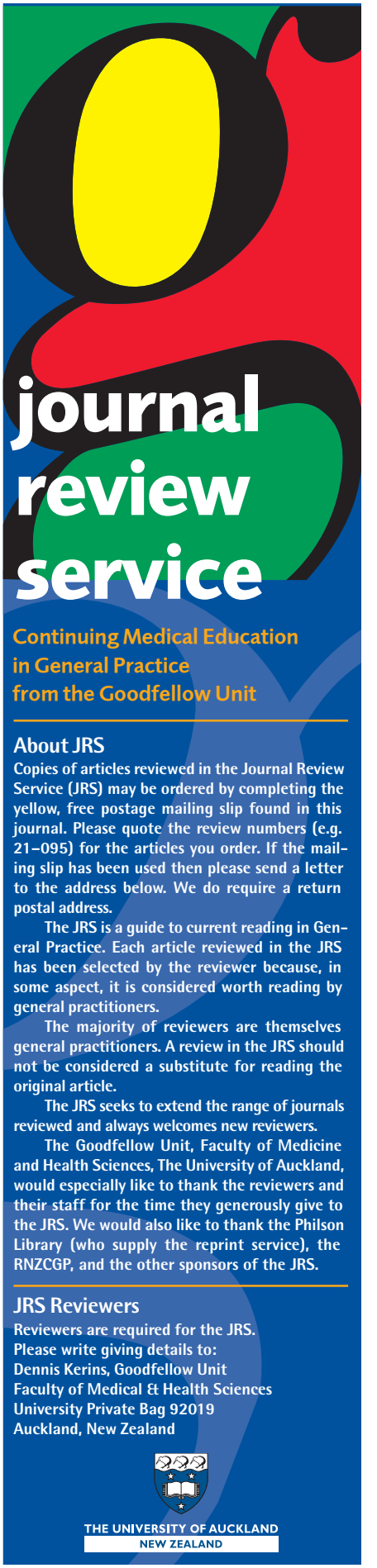
Review: This study investigated and compared the efficacy of standard treatment, standard treatment plus acupuncture (30 minutes twice per week for six weeks), and standard treatment plus stabilising exercises (training and treatments for total of six hours during the six weeks) for pelvic girdle pain during pregnancy. Three hundred and eighty-six pregnant women with pelvic girdle pain were randomised to one of these forms of treatment for six weeks. Outcome measures included mornings and evenings VAS pain scale and assessment of recovery from symptoms. The study was organised to include a one week baseline period, six weeks of treatment, and one week follow-up after the last treatment. Results showed that reduction in pain one week after the end of treatment was most pronounced in the evening in the acupuncture adjunct group comparing with the other treatment groups. Reduction in pelvic girdle pain symptoms as assessed by the blinded independent examiner was also greatest in the acupuncture adjunct group comparing with the other groups. Stabilising exercises adjunct group also fared better than the standard treatment group.

Comment: In this study, the acupuncture points were selected in muscle segments according to the patient's pain drawing, and also sensitive points identified by diagnostic palpation. Extra segmental points to the lumbosacral area were also used in addition to GV-20 and LI-4. This study also showed that combination of therapeutic measures led to better outcomes.

25-259 Auricular acupuncture for pain relief after total hip arthroplasty – a randomized controlled study.

Usichenko TI, Dinse M, Hermsen M, et al. Pain. April 2005. Vol.114. No.3. p.320-7.
Reviewed by Dr Alex Chan

Review: This was a prospective randomised patient- anaethesiologist-evaluator-analyst blinded, sham acupuncture controlled study. Auricular acupuncture of specific points (lung, shenmen, thalamus and hip points) or non-acupuncture points on the ear was performed with disposable permanent press steel AA needles the night before surgery. The needles were fixed with flesh-coloured adhesive tape and retained in-situ for three days after surgery. Patient-controlled analgesia pump with piritramide (an opioid



receptor agonist) was connected to the patients post-operatively for three days after the first request for pain relief. The aim was to keep the pain intensity reported by the patients to less than 40mm on a 100mm visual analogue scale. It was found that the true auricular acupuncture group required less piritramide (32% less) than the control group during the 36 hours after surgery.

Comment: It is interesting to note that pain intensity on VAS-100 was similar in both groups. The authors rightfully pointed out that sham acupuncture, being an invasive procedure, would always lead to physiological reaction such as the triggering of diffuse noxious inhibitory control which could contribute to a placebo effect, thus diminishing the comparative effect of genuine point-specific acupuncture.

Asthma

25–260 Daily versus as–needed corticosteroids for mild persistent asthma.

Boushey HA, Sorkness CA, King TS, et al. N Engl J Med. 14 April 2005. Vol.352. No.15. p.1519-28.

Reviewed by Dr Raina Elley

Review: This was a double blind randomised controlled trial of intermittent short course inhaled corticosteroid treatment for exacerbations of asthma or in addition to either daily inhaled corticosteroid or oral zalfirlukast, over 12 months amongst 225 adults with mild asthma. There was no difference in daily PEFR, frequency of exacerbations, quality of life or post-bronchodilator FEV1. However, daily-inhaled corticosteroid (budesonide) did produce better scores for symptom control, pre-bronchodilator FEV1 and bronchial reactivity, lower exhaled nitric oxide levels, and more symptom-free days.

Comment: The authors conclude that it may be appropriate to use intermittent inhaled corticosteroid use in people with mild asthma. However, there are some benefits in the long-term inhaled corticosteroid use. I expect the benefits must be weighed against the cost and potential adverse effects.

25–261 Use of exhaled nitric oxide measurements to guide treatment in chronic asthma.

Smith AD Cowan JO, Brassett KP, et al. N Engl J Med. 26 May 2005. Vol.352. No.21. p.2163-73.

Reviewed by Dr Raina Elley

Review: This was a randomised controlled trial assessing the use of exhaled nitric oxide fractions (FENO) to adjust inhaled corticosteroids, amongst 97 patients with asthma over 12 months in New Zealand. The control group had their doses adjusted according to thresholds in bronchodilator use symptoms, peak flows and spirometry. Patients started on a dose of 750mcg/day fluticasone and were titrated according to FENO or control protocols every four weeks (usually step-wise down, but maximum of 1000mcg/day). Primary outcome was number of exacerbations; secondary outcome was the mean daily dose of fluticasone. Patients were blind to allocation of intervention and dose of fluticasone. At 12 months, the FENO group had fewer exacerbations (although not statistically significant) and they used 270mcg/day less fluticasone than the control group (370mcg vs 641mcg), which was statistically significant.

Comment: Apparently FENO increases in proportion to bronchial wall inflammation, so FENO is a sensitive and easily measured marker of deterioration in asthma control. If the amount of inhaled corticosteroid can be reduced by this amount using FENO compared with more conventional measures, this could have a substantial cost saving in pharmaceutical expenditure, reduce the risk of side effects and potentially improve control. The study protocol of this study was very clever and the intervention innovative and useful to inform future practice.

25–262 Aspirin–sensitive asthma.

Morwood K, Gillis D, Smith W, et al. Intern Med J. April 2005. Vol.35. No.4. p.240-6.

Reviewed by Dr Helen Moriarty

Review: A discussion/review article about this common problem in adult asthmatics. Have you heard about desensitisation to aspirin? This is an option for patients who need aspirin for a comorbid cardiac condition. Nasal polyps go had in hand with this condition – but often recur after surgery and do not respond in the long-term to steroid courses.

Cardiovascular System

25–263 A randomized trial of low–dose aspirin in the primary prevention of cardiovascular disease in women.

Ridker PM, Cook NR, Lee I-M et al. Lancet. 31 March 2005. Vol.352. No.13. p.1293-304.

Reviewed by Dr Raina Elley

Review: This is a randomised controlled trial of 100mg aspirin on alternate days, amongst 39 876 women (doctors) over 45 years, without previous cardiovascular disease, followed for 10 years. Primary outcomes included first major cardiovascular event, myocardial infarction (MI), stroke (ischaemic and haemorrhagic) and death from any cardiovascular event. Although there was evidence for aspirin use in acute MI and for secondary prevention in men and women, and for use as primary prevention of MI (but not stroke) amongst men, there was not evidence for effectiveness of aspirin in primary prevention of cardiovascular events in women. This large trial showed a reduction in stroke (Relative Risk of 0.83, p=0.04), particularly ischaemic stroke (RR of 0.76, p=0.009), but no reduction in MI. Gastrointestinal bleeding (all and those requiring transfusion) and peptic ulceration and other causes of bleeding increased significantly in the intervention group compared with the control group. The article also includes meta-analyses of the effect of aspirin for

cardiovascular event prevention, and several interesting sub-group analyses (e.g. aspirin is less effective in those who currently smoke). Most notably the sub-group analysis of women over 65 years showed significant reductions in major cardiovascular events, ischaemic stroke and MI.
Comment: It is interesting to note that in primary prevention, low dose aspirin reduces the risk of MI but not stroke amongst men, yet reduces the risk of stroke but not MI amongst women (over 45 years).

25–264 Optimal oral antiplatelet therapy for vascular disease.

J Fam Pract. January 2005. Vol.54. No.1. p.23.
Reviewed by Dr Bruce Adlam
Review: Which antiplatelet agents, used alone or in combination, are effective in preventing recurrent vascular events? In this systematic review, aspirin is the recommended oral first-line antiplatelet therapy for patients with ST-segment elevation myocardial infarction. Aspirin or clopidogrel is recommended for those with initial transient ischaemic attack (TIA)/ischaemic stroke, chronic stable angina, or peripheral arterial disease; aspirin plus clopidogrel should be used for those with non-ST-segment elevation acute coronary syndrome. For second-line therapy, the combination of aspirin and clopidogrel is recommended for recurrent acute coronary syndrome. The combination of aspirin and extended-release dipyridamole is recommended for patients with recurrent TIA/ischaemic stroke in the absence of known coronary artery disease. Further studies are needed before making firm recommendations on the management of patients with recurrent TIA/ischaemic stroke and known coronary artery disease. (Level of evidence =1a) (Original article reviewed: JAMA 2004; 292: 1867-74).

25–265 Percutaneous carotid artery stenting: a strategy in evolution.

Kovacic JC, Roy PR, Baron DW, et al. Intern Med J. March 2005. Vol.35. No.3. p.143-50.
Reviewed by Dr Helen Moriarty
Review: A retrospective analysis of 111 patients who underwent stenting of carotid arteries in a six year period up to 2003. 'Most' patients were candidates for endarterectomy. In 99.2% the stents were placed successfully. The advantage was in hospital stay (only one day) and low peri-procedural health or stroke event rate (2.5%).
Comment: Author concludes that this is a feasible future intervention, preferable to endarterectomy, and it should become as routine as coronary stenting in future. Sadly there was no control group for comparison – and coronary stenting indications are now themselves under review. 'So watch this space...'

25–266 Intensive lipid–lowering therapy and atherosclerosis.

Wellbery C. Am Fam Physician. 15 October 2005. Vol.70. No.8. p.1580-1.
Reviewed by Dr Bruce Arroll
Review: This paper reviewed a randomised controlled trial of atorvastatin 80mg daily (intensive therapy) versus pravastatin 40mg (moderate therapy). The patients were those who required angiography and in addition had intravascular ultrasonography to measure the volume of atherosclerosis. There was no progression in the atorvastatin group but there was positive progression in the pravastatin group. There was also a greater reduction in the c-reactive protein in the intensive group. Baseline LDL levels were between 3.24 and 5.43 mmol/l. The authors referred to an article in the N Engl J Med 2004; 350:1495–504 which found a 4% absolute risk reduction in outcomes using these two interventions. That translates to a numbers needed to treat of 25 to get one additional benefit by giving the high dose atorvastatin. (Original article reviewed: JAMA 2004; 291: 1071-80).
Comment: There seems to be no lower limit to which LDL can be lowered to get a cardiovascular benefit. It turns out that at birth our LDLs are about 1 mmol/l so expect there to be more studies finding lower is better. There is an issue of cost effectiveness here. Naturally the most benefit comes with the lower doses and gets increasingly more expensive to get the last few percentage reductions.

25–267 Adding ACE inhibitor doesn't improve outcomes in stable angina and normal LVEF.

J Fam Pract. February 2005. Vol.54. No.2. p.109, 113.
Reviewed by Dr Bruce Adlam
Review: Adding the angiotensin-converting enzyme (ACE) inhibitor trandolapril to standard medical treatment of patients with stable angina and normal left ventricular function did not reduce their risk of adverse cardiovascular outcomes (Level

of evidence=1b). Higher-risk patients and those with less well controlled risk factors were not assessed in this RCT. (original article reviewed: N Engl J Med 2004; 351: 2058-68.)
Comment: The HOPE and EUROPA trials found that ACE inhibitors improved cardiovascular outcomes in patients with vascular disease but with no evidence of overt heart failure. This study attempted to extend these findings to an even lower-risk group.

Cerebrovascular System

25–268 Homocysteine levels and reduction of stroke risk.

Wellbery C. Am Fam Physician. 15 October 2005. Vol.70. No.8. p.1561.
Reviewed by Dr Bruce Arroll
Review: This paper reviews the results of a randomised controlled trial of high dose multivitamin (25mg pyridoxine, 0.4mg cobalamin, 2.5mg folic acid) versus low dose (200mcg pyridoxine, 6mcg cobalamin, 20mcg folic acid) in those who had already had a stroke. There was no difference between the two doses. A subgroup analysis in the low dose group found that there was an effect in those with very high levels of homocysteine. (Original article reviewed: JAMA 2004; 291: 565-75).
Comment: The issues of vitamins and their effect on homocysteine and subsequent stroke is still unresolved as caution is needed with subgroup analysis.

Communicable Diseases, Infections and Parasites

25–269 Interventions for impetigo.

Taylor JS. Am Fam Physician. 1 November 2004. Vol.70. No.9. p.1680-1.
Reviewed by Dr Bruce Arroll
Review: A review article for the treatment of impetigo. The author states that topical mupirocin (bactroban) is as effective or possibly more effective than oral treatments in patients with limited disease. Limited evidence does not support the use of disinfectants. Fusidic acid is as effective as mupirocin.
Comment: In New Zealand there is about a 30% resistance with s.aureus to mupirocin. There is a move to use oral medication for treatment of impetigo rather than topicals as there is a desire to preserve the topicals for removing staphylococcus from the nose.

Contraception and Family Planning

25–270 Delayed childbearing: Ensuring life choices are informed.

O'Connor V, Johnson K. Aust Fam Physician. March 2005. Vol.34. No.3. p.102.
Reviewed by Dr Rachel Monk
Review: 'The average age for a first pregnancy in Australia is now 27.' The reasons for delaying first pregnancy are many and varied but the question is 'Is this choice an informed one?'

25–271 'We're having trouble conceiving...'

Quinn F. Aust Fam Physician. March 2005. Vol.34. No.3. p.107-10.
Reviewed by Dr Rachel Monk
Review: This article gives a general overview of causes of infertility and a targetted approach GPs can take. Also included are the normal values for semen analysis.
Comment: Remember simple advice is often all that is required – e.g. weight loss if BMI >30, adequate frequency of intercourse (two to three times weekly).

25–272 Management of the infertile couple.

McLachlan RI, Yazdani A, Kovacs G, et al. Aust Fam Physician. March 2005. Vol.34. No.3. p.111-7.
Reviewed by Dr Rachel Monk
Review: This article is fairly detailed about the main causes of male and female infertility and their investigation and management. Suggests not waiting for 12 months but to do simple noninvasive tests earlier if couple present with concerns, especially if they are of older age.

25–273 The ART of assisted reproductive technology.

Persson J. Aust Fam Physician. March 2005. Vol.34. No.3. p.119-22.
Reviewed by Dr Rachel Monk
Review: Nice brief article discussing the main assisted reproductive techniques (ART) including ovulation induction, intrauterine insemination, IVF and ICSI.
Comment: There is also a short section on preimplantation genetic diagnosis.

25–274 Developments in infertility therapy: Diagnosis of genetic disease in embryos.

Trounsen A. Aust Fam Physician. March 2005. Vol.34. No.3. p.123-5.
Reviewed by Dr Rachel Monk
Review: If management of fertility is an interest for you then read this article. Useful to have the latest information to share with couples in your practice who are going through the process.

25–275 Polycystic ovary syndrome: A management update.

Costello MF. Aust Fam Physician. March 2005. Vol.34. No.3. p.127-33.
Reviewed by Dr Rachel Monk
Review: PCOS affects 4–7% of reproductive aged women so it is good for GPs to know about this!
Comment: Good guide in diagnosis, health risks and management of this common disorder, focusing on both the reproductive and the metabolic issues.

25–276 Basal body temperature chart.

McLachlan RI, Yazdani A, Kovacs G, et al. Aust Fam Physician. March 2005. Vol.34. No.3. p.139-40.
Reviewed by Dr Rachel Monk
Review: Helpful guide for patients trying to chart their menstrual cycle and temperature.

Diagnosis

25-277 Beauty is in the eye of the examiner: reaching agreement about physical signs and their value.

Joshua AM, Celermajer DS, Stockler MR. Intern Med J. March 2005. Vol.35. No.3. p.178-87.
Reviewed by Dr Helen Moriarty

Review: This timely article asks what is the accuracy and reliability of physical examination and common physical signs. It challenges well-held belief systems such as 'irregularly irregular pulse in atrial fibrillation'. In fact 30% of patients with AF may have periods of pulse regularity, 50% with normal pulse volume. Tables in this article show the levels of disagreement in presence or absence of signs such as tachypnoea, tactile fremitus, splenomegaly, neck stiffness.
Comment: Key points for discussion include reliance of signs (or absence of signs) in situations where clinical safety implications may be significant. There are also questions about skills training and the role of uncertainty when teaching future doctors.

25-278 Evaluating the patient with an ankle or foot injury.

Ebell MH. Am Fam Physician. 15 October 2005. Vol.70. No.8. p.1535-6.
Reviewed by Dr Bruce Arroll

Review: An overview of the Ottawa ankle rules. This has been validated in a number of settings. It has very low rate of missing fractures (false negatives) but at the price of some unnecessary ankle x-rays (false positives).
Comment: A very succinct summary.

25-279 Blood pressure monitors.

Am Fam Physician. 15 October 2004. Vol.70. No.8. p.1547-8.
Reviewed by Dr Bruce Arroll

Review: This is more a review of home blood pressure monitors. It would also be useful for patients to read if they are interested in home BP measurement.
Comment: Good summary of home blood pressure monitors.

Ear, Nose and Throat

25-280 Implantable hearing devices: Beyond hearing aids.

Chang P. Aust Fam Physician. March 2005. Vol.34. No.3. p.157-61.
Reviewed by Dr Rachel Monk

Review: Hearing loss is common and conventional hearing aids are not always adequate. Have a read about some new devices now available in clinical practice.

Education

25-281 Yada Yada Yada or carpe somnum.

McCrory P. Br J Sports Med. 1 April 2005. Vol.39. No.4. p.187.
Reviewed by Dr Chris Milne

Review: People at conferences often fall asleep – why does this happen? Some Canadians studied the problem. They concluded that most of the risk factors for the audience falling asleep (Nod-off episodes per lecture) were speaker related. These included monotonous tone (odds ratio 6.8); speaker wearing a tweed jacket (odds ratio 2.0); Speaker losing place in the lecture (odds ratio 2.0); poor slides (odds ratio 1.8) and failure to speak into the microphone (odds ratio 1.7)
Comment: A great article. This should be read by all those who present at conferences or grand rounds. You should think of the lecture as at least a partly theatrical experience and you won't go far wrong!

Endocrinology

25-282 Can type 2 diabetes be prevented through diet and exercise?

Warnken W, Kelsberg G, Bryant S. J Fam Pract. January 2005. Vol.54. No.1. p.78-80.
Reviewed by Dr Bruce Adlam

Review: The results of three large prospective RCTs were included in this evaluation. Diets that result in long-term weight loss of 5% to 7%, along with moderate-intensity exercise for more than 150 minutes per week, reduce the incidence of type 2 diabetes for patients with impaired glucose tolerance (strength of recommendation: A). Each of the trials demonstrating this finding included fairly intensive counselling as part of the successful intervention.
Comment: There is probably a small window of opportunity to reach the motivated patient when they first learn they have impaired glucose tolerance. This may be the time for primary care to put in some extra effort or if time does not permit, refer to other health professionals (dietician, exercise professionals).

25-283 Substance abuse in young patients with type 1 diabetes: easily neglected in complex medical management.

Lee P, Nicoll AJ, McDonough M, et al. Intern Med J. June 2005. Vol.35. No.6. p.359-61.
Reviewed by Dr Helen Moriarty

Review: Case reports are given, which illustrate the importance of thinking about substance abuse as a complicating feature of chronic disease. This was a factor that worsened the chronic conditions or caused additional illness presentations. It was either pre-existing (and sometimes aetiolgical) or a maladaptive response to the chronic disease.
Comment: Personal experience in NZ aligns well with the findings of this paper. Cannabis, tobacco and alcohol are the common co-existing problems in NZ patients with chronic illness. Yet we often don't even think to ask...

25-284 Coffee consumption and risk of type 2 diabetes.

Wellbery C. Am Fam Physician. 15 October 2004. Vol.70. No.8. p.1579.
Reviewed by Dr Bruce Arroll

Review: This paper reports the finding of a Finnish cohort study lasting 12 years, which examined the relationship between coffee intake and the onset of diabetes mellitus. Coffee consumption was categorised as

0–2 cups, 3-4, 5-6, 7-9 and more than 10 cups daily. The authors found an inverse association between diabetes and coffee consumption. When controlling for sociodemographic factors the findings remained significant in women and as a significant trend in men with a significant reduction in diabetes risk in those who drank at least 10 cups per day. (Original article reviewed: JAMA 2004; 291: 1213-9.)
Comment: At this point there is no scientific explanation for these findings.

25-285 Tight blood pressure control prevents blindness in patients with diabetes.

J Fam Pract. February 2005. Vol.54. No.2. p.106.
Reviewed by Dr Bruce Adlam
Review: Tight blood pressure control results in a small benefit in the prevention of blindness, with a number needed to treat of 1000 per year. Tight control was also associated with a reduction in loss of visual acuity after nine years (but not with shorter durations of follow-up) and an increase in the likelihood of cataract extraction. (LOE=1b) (Original article reviewed: Arch Ophthalmol 2004; 122: 1631-40.)
Comment: An interesting finding of unknown significance was that 36 patients in the tight control group required cataract extraction compared with only 14 in the loose control group.

25-286 ARB no better than ACE inhibitor for prevention of nephropathy progression.

J Fam Pract. February 2005. Vol.54. No.2. p.108-9.
Reviewed by Dr Bruce Adlam
Review: In this double blind RCT, and despite a relatively low dose of 10mg given once a day, enalapril was at least as effective as telmisartan and showed a trend toward greater benefit in preventing decline in glomerular filtration rate. Although this study measured a disease-oriented endpoint, its results are consistent with the body of literature that supports the less expensive angiotensin-converting enzyme (ACE) inhibitors as the drug of choice over angiotensin receptor blockers (ARBs). (Level of evidence =11b) (Original article reviewed: N Engl J Med 2004; 351: 1952-61.)

Ethics

25-287 How far does a doctor's 'duty of care' go?

Torda A. Intern Med J. May 2005. Vol.35. No.5. p.295-6.
Reviewed by Dr Helen Moriarty
Review: A short article that cites the SARS outbreak experience to highlight the dilemma of having to decide against competing duties to: self, family, business, employer, etc. and patients themselves, as well as duty to guard from spread of infection to our own families and contacts. Article asks 'which duty would most people feel to be the stronger?'
Comment: Short, to the point, thought-provoking and well worth a read.

25-288 Ethical issues in the relationships involving medicine and industry: evolving problems require evolving.

Komesaroff P. Intern Med J. April 2005. Vol.35. No.4. p.203-5.
Reviewed by Dr Helen Moriarty
Review: This editorial refers to a larger article (See 25-289) which surveyed medical organisations about industry sponsorship. The need to be independent and transparent in decision making is not under question. However, the involvement of industry (read drug companies) occurs at many levels, some very subtle, ranging from meeting sponsorship to subsidising services and equipment.
Comment: RACP has a policy on ethical relationships with pharmaceutical companies – but it focusses on the relationship at individual doctor level, rather than the wider and more invisible impact on medical organisations supporting the doctor.

25-289 Cooperative partnerships or conflict-of-interest? A national survey of interaction between the pharmaceutical industry and medical organizations.

Kerridge I, Maguire J, Newby D, et al. J Fam Pract. April 2005. Vol.35. No.4. p.206-10.
Reviewed by Dr Helen Moriarty
Review: See 25-288.

Gastroenterology

25-290 Ear, nose, and throat manifestations of gastroesophageal reflux disease: Complaints can be telltale signs.

Burton LK, Murray JA, Thompson DM. Postgrad Med. February 2005. Vol.117. No.2. p.39-45.
Reviewed by Dr Chris Milne
Review: Reflux can present with chronic cough, voice change, globus symptoms and even earache. Because it is such a common condition, it is worth looking for. The gold standard for diagnosis in atypical cases is 24 hour ambulatory pH monitoring. The availability of this in many settings in NZ is limited, and trial of a proton pump inhibitor for a month may be an aid to diagnosis.
Comment: Useful article about an important condition.

Geriatrics

25-291 Oral vitamin D3 and calcium for secondary prevention of low-trauma fractures in elderly people (Randomised Evaluation of Calcium Or vitamin D, RECORD): a randomised placebo-controlled trial.

The RECORD Trial Group. Lancet. 7-13 May 2005. Vol.365. No.9471. p.1621-8.
Reviewed by Dr Tony Hanne
Review: Over 5000 Scottish patients aged 70 or over who had already suffered a low-trauma fracture were randomised into four treatment groups, calcium 1000mg daily alone, vitamin D 800iu alone, calcium and vitamin D combined, or placebo. About one-eighth suffered a further fracture. They were followed for between two and five years. There was

no difference in the likelihood of fracture between the four groups.
Comment: Various objections could be made to extrapolating this study throughout the whole elderly community on the grounds that the more severely ill were excluded, or that different doses of calcium or vitamin D might have produced different results, but it is consistent with what is known about the physiology of osteoporosis. See also 25-292.

25-292 Vitamin D and fractures: quo vadis?

Sambrook P. Lancet. 7-13 May 2005. Vol.365. No.9471. p.1599-600.
Reviewed by Dr Tony Hanne
Review: The accompanying editorial for the article on vitamin D3 and calcium in the same issue – see 25-291.

25-293 Effect of hormone therapy on cognition in elderly women.

Wellbery C. Am Fam Physician. 15 October 2004. Vol.70. No.8. p.1575-6.
Reviewed by Dr Bruce Arroll
Review: This was a case comparison with matched controls in older women who were receiving oestrogen supplementation for improvement of cognitive performance. There was no difference between the groups. The editors pointed out that there is a larger randomised trial but the results are not due until 2010. They also pointed out that short-term therapy used near the onset of dementia or in the treatment is not effective. (Original article reviewed: J Am Geriatr Soc 2004; 52: 182-6)
Comment: At this point oestrogens are not indicated as a treatment or prevention of dementia.

Guidelines

25-294 Analysis and overview of the guidelines for assessing fitness to drive for commercial and private vehicle drivers.

Beran RG. Intern Med J. June 2005. Vol.35. No.6. p.364-8.
Reviewed by Dr Helen Moriarty
Review: Although an overview of the Australian National Road Transport Commission, this makes fascinating reading. It is published as a 'Personal Viewpoint', but clearly has raised some pertinent questions about guidelines drawn up by government agencies for the medical profession to follow. There were serious flaws in this particular document including inappropriate language, non-scientific constructs, no legal obligation for health professionals to notify conditions, conflict with Privacy Act.
Comment: This reminded me of recent problems with the Immigration Medical for residency applications.

Gynaecology

25-295 Laparoscopic vs. abdominal hysterectomy: a comparison.

Walling AD. Am Fam Physician. 15 October 2004. Vol.70. No.8. p.1570-1, 75.
Reviewed by Dr Bruce Arroll
Review: Reports the findings of two parallel randomised trials using the above three operative techniques. The patients were having surgery for non-malignant conditions and had a uterine size of less than 12 weeks gestation and no evidence of prolapse. The results were surprising. There was more major haemorrhage in the laparoscopic group than in either of the other approaches. Compared with abdominal hysterectomy there was more bladder injury in the laparoscopic group. (Original articles reviewed: BMJ 2004; 328: 129-33 & 134-7)
Comment: This information would be useful for patients trying to decide what procedure they should undertake.

25-296 Management of benign breast conditions Part 1 – painful breasts.

Brennan M, Houssami N, French J. Aust Fam Physician. March 2005. Vol.34. No.3. p.143-5.
Reviewed by Dr Rachel Monk
Review: This is the first of a series on breast symptoms, which are common reasons for women to present to a GP. Mastalgia affects up to 77% of women at some time in their lives. This short article provides a useful guide of how to approach women with breast pain.
Comment: Patient handout on page 145.

25-297 Recurrent vulvovaginal candidiasis.

Sheary B, Dayan L. Aust Fam Physician. March 2005. Vol.34. No.3. p.147-50.
Reviewed by Dr Rachel Monk
Review: This frustrating problem affects about 5% of premenopausal women. Be wary of clinical self-diagnosis alone – less than half of women get the correct diagnosis. Emphasis on confirmation of candida with examination and culture, particularly in women with recurrent symptoms.
Comment: A summary of treatment options also in this article.

Health Services

25-298 Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK.

Eastwood JB, Conroy RE, Naicker S, et al. Lancet. 28 May - 3 June 2005. Vol.365. No.9474. p.1893-900.
Reviewed by Dr Tony Hanne
Review: About half the new medical graduates of sub-Saharan African countries settle in developed countries particularly the UK and USA. About half the new medical registrants in the UK are from non-EU countries. This represents a huge loss of doctors in the poorest countries as well as a major financial loss for countries which have borne the cost of training which their economies struggled to afford. The article maps the doctor levels country by country around the world which range from less than two per 100 000 in Malawi to more than 600 per 100 000 in Italy. The causes of migration which are mainly around incomes, postgraduate training opportunities, facilities and social conditions are explored. Some possible solutions are discussed.

Comment: While the sources of migrant doctors and nurses in New Zealand are somewhat different, the principle of the 'medical carousel' is the same. By not training enough doctors to meet our own needs, particularly in general practice, we inevitably suck much needed doctors out of poor countries. An immigration policy of recruiting skilled migrants runs exactly counter to a supposed commitment to overseas aid.

Law and Medicine

25-299 Medical work hours: time for a Maggie's Law for doctoring?

Grunstein RR, Rogers NL. Intern Med J. May 2005. Vol.35. No.3. p.269-71.
Reviewed by Dr Helen Moriarty

Review: 'Maggie's Law' is a culpability law for driving offences committed under sleep deprivation situations. This editorial and two articles in N Engl J Med question the safety of medical decision-making due to shift work, on call hours, and inexperienced junior staff on unsupported duty and the 'superspecialty' staff for whom rarity means high rostering.
Comment: OSH in NZ and a similar law in Australia seek to find a 'chain of responsibility' for work safety issues. If this applied to doctoring, where would workforce responsibility lie?

Metabolic Diseases

25-300 Sedentary behaviors, physical activity, and metabolic syndrome in middle-aged French subjects.

Bertrais S, Beyeme-Ondoua J-P, Czernichow S, et al. Obes Res. May 2005. Vol.13. No.5. p.936-44.
Reviewed by Dr Anne-Thea McGill

Review: In a cross sectional study of 3800 middle-aged Central France adults the frequency of most Metabolic Syndrome components (waist, BP, glucose, TAG, HDL) decreased by one-third in subjects meeting moderate PA guidelines and by two-thirds in subjects meeting vigorous PA recommendations in women and by 0.44 in men compared with those with insufficient PA. [1) insufficient activity, no leisure time physical activity (LTPA) reported or some LTPA but below level 2; 2) moderate activity,= 150 min/wk of LTPA = 3 METs but below level 3; and 3) vigorous activity, =60 min/wk of LTPA =6 METs during =20 minutes per session]. Independently of PA levels, time spent in front of a screen was positively associated with the likelihood to have the MS in women [odds ratio (95% CI), 3.30 (2.04 to 5.34)], whereas in both sexes, no association was found with time spent reading.
Comment: This European study, although cross-sectional and questionnaire based, appears to be thorough and indicates that we should be encouraging PA and less screen time to prevent or ameliorate obesity, and the more intense activity the better. There is something about sedentariness and screen viewing that is worse than reading, particularly for women in this study – is it junk food ingestion?

Musculoskeletal System

25-301 Exercises for improving bone strength.

Turner CH, Robling AG. Br J Sports Med. 1 April 2005. Vol.39. No.4. p.188-9.
Reviewed by Dr Chris Milne

Review: Dynamic loading is the most effective, as this generates shear stresses on the plasma membranes of osteocytes. Prolonged exercise has diminishing returns (just like every other law of diminishing returns).
Comment: This is a good general article, but we now need a practically focussed article on specific exercises for improving bone strength at specific sites in the skeleton.

25-302 Comparison of physical treatments versus a brief pain-management programme for back pain in primary care: a randomised clinical trial in physiotherapy practice.

Hay EM, Mullis R, Lewis M, et al. Lancet. 11-17 June 2005. Vol.365. No.9476. p.2024-30.
Reviewed by Dr Tony Hanne

Review: This English trial compared two groups of patients of about 200 each with low back pain for less than 12 weeks. One group was treated by physiotherapy including manual techniques and psychosocial support. The other group were treated only by brief sessions for standard pain management. Reduction in disability at 12 months was assessed. There was no difference between the two groups.
Comment: Clinical guidelines have strongly recommended early intervention with physiotherapy by various modalities together with good psychosocial support. This study casts doubt on the evidence base for such advice. It may still be that in the art of medicine lies the ability to detect which patient will benefit from which plan of management. See also 25-303.

25-303 Treating low back pain.

Shekelle PG, Delitto AM. Lancet. 11-17 June 2005. Vol.365. No.9476. p.1986-7.
Reviewed by Dr Tony Hanne

Review: The accompanying editorial for the article on low back pain in the same issue – see 25-302.

25-304 Physical examination of the shoulder in the primary care setting.

McShane JM, Graveley MJ, Hopper BD. Prim Care. December 2004. Vol.31. No.4. p.783-8.
Reviewed by Dr M Hewitt

Review: A good 'how to' exercise.
Comment: Reviews the basics, and is a good supplement to the ACC series of shoulder injury management.

25-305 Shoulder impingement syndrome.

Henrichs J, Stone D. Prim Care. December 2004. Vol.31. No.4. p.789-805.
Reviewed by Dr M Hewitt

Review: As the title suggests.
Comment: A good review of the topic.

25-306 Rotator cuff injuries and treatment.

Browning DG, Desai MM. Prim Care. December 2005. Vol.31. No.4. p.807-29.
Reviewed by Dr M Hewitt

Review: A good in-depth assessment of clinical descriptions and aids to

the diagnosis. Functional application of the known anatomy and biomechanics make the recommendations for treatment more appropriate and precise.
Comment: Does a good examination preclude the need for an MRI prior to arthroscopy? That depends...

25–307 Superior labrum, anterior–posterior lesions and biceps injuries: diagnostic and treatment considerations.
Harwood MI, Smith CT. Prim Care. December 2004. Vol.31. No.4. p.831-55.
Reviewed by Dr M Hewitt
Review: There are more common encounters of these type of injuries due to the nature of high impact adventure lifestyles as well as those of the professional athlete.
Comment: The close relationship of these structures allows for a discussion of them as an entity on their own.

25–308 The acromioclavicular joint.
Montellese P, Dancy T. Prim Care. December 2005. Vol.31. No.4. p.857-66.
Reviewed by Dr M Hewitt
Review: A variety of mechanisms of injury can affect this joint. The diagnosis may be straightforward, but the authors discuss complications of injury such as chronicity and recommend best management.
Comment: Not always to operate!

25–309 Shoulder instability.
Johnson R, Lehnert S, Moser B, et al. Prim Care. December 2005. Vol.31. No.4. p.867-86.
Reviewed by Dr M Hewitt
Review: This condition can occur from acute or chronic causes such as overuse. Treatment considerations involve non-surgical rehabilitation. A full assessment requires imaging.
Comment: MRI again.

25–310 Physical examination of the knee.
Allen JE, Taylor KS. Prim Care. December 2005. Vol.31. No.4. p.887-907.
Reviewed by Dr M Hewitt
Review: A good examination aid-memoire, also includes a well-taken history.
Comment: Similar to that provided by ACC guidelines without automatic referral for MRI.

25–311 Patellar tendonitis and patellar dislocations.
Morelli V, Rowe RH. Prim Care. December 2004. Vol.31. No.4. p.909-24.
Reviewed by Dr M Hewitt
Review: The authors make a careful distinction between acute and chronic cases, and provide appropriate recommendations for each. The general principle being for conservative measures mainly in rehabilitation and surgery only for the difficult non-responders.

25–312 Physical therapy adds little to back pain treatment.
J Fam Pract. January 2005. Vol.54. No.1. p.19.
Reviewed by Dr Bruce Adlam
Review: In this single blind RCT, physical therapy sessions in a specialty outpatient setting did not offer any additional benefit over simple advice to remain active in patients referred for physical therapy. Patients initially perceived a benefit while being treated, but this benefit disappears by one year (Level of evidence =2b). Treatment sessions of physical therapy were defined as using joint mobilisation and manipulation, soft tissue techniques, and strengthening exercises. (Original article reviewed: BMJ 2004; 329: 708-13).
Comment: Follow-up at one year was only 70%. It would be nice to know who was in this group.

25–313 Useful treatments for fibromyalgia syndrome.
J Fam Pract. February 2005. Vol.54. No.2. p.105.
Reviewed by Dr Bruce Adlam
Review: A total of 505 articles were reviewed in this study. Treatments for fibromyalgia syndrome with the strongest evidence for efficacy include amitriptyline, cyclobenzaprine, exercise, cognitive behavioural therapy, patient education, and multidisciplinary therapy. (Level of evidence 1a) There was some modest evidence for tramadol, various SSRIs, acupuncture, hypnotherapy, and biofeedback. Weak evidence for efficacy was found for growth hormone therapy, SAM (S-adenosyl-methionine), chiropractic and massage therapy, electrotherapy, and ultrasound. No evidence of any evaluation or effectiveness was found for steroids, nonsteroidal anti-inflammatory drugs, melatonin, benzodiazepine hypnotics, or trigger-point injections. (Original article reviewed: JAMA 2004; 292: 2388-95.)

Neurology

25–314 'Tomber dans les pommes' – can head injury cause brain damage?
McCrory P. Br J Sports Med. 1 March 2005. Vol.39. No.3. p.125-6.
Reviewed by Dr Chris Milne
Review: Two Canadian children and their father analysed the adventures of Tintin in an attempt to discover why he grew no taller from 1929 to 1975, never had a girlfriend and never needed to shave. They identified 50 episodes of head injury, mean duration of loss of consciousness 7.5 frames, and postulate these resulted in hypogonadotrophic hypogonadism and growth hormone deficiency.
Comment: Alert for Tintin fans – this article will provide some excellent light relief from what can often be a turgid process (reading journal articles that is!).

Obstetrics

25–315 Effect of treatment of gestational diabetes mellitus on pregnancy outcomes.
Crowther CA, Hiller JE, Moss JR, et al. N Engl J Med. 16 June 2005. Vol.352. No.24. p.2477-86.
Reviewed by Dr Raina Elley
Review: This was a multi-centred randomised controlled trial of 1000 pregnant women diagnosed with carbohydrate intolerance between 24

and 34 weeks (GTT with fasting plasma glucose <7.8 mmol/l and 2-hour glucose of 7.8-11.0 mmol/l). The intervention group were told they had carbohydrate intolerance and given dietary advice, glucose self-monitoring four times daily and insulin therapy to maintain fasting glucose of 3.5-5.5 mmol/l and post- prandial glucose no more than 7.0 mmol/l. The control group were told they did not have gestational diabetes and were not monitored further unless frank symptoms of diabetes appeared. Outcome variables for the infants included serious perinatal complications, admission to neonatal nursery, and jaundice. Primary outcomes for the women included need for induction of labour, LSCS, post-natal quality of life (SF36), anxiety and depression. Serious peri-natal complications (death, shoulder dystocia, fracture or nerve palsy) were lower in the intervention group compared with the control (1% vs 4%, p=0.01), but admissions to neonatal nurseries were more common. Intervention women were more likely to have induced labour but had better mood and quality of life compared with control women three months post-partum. (See 25-316)

Comment: This trial supports the case for screening of at-risk women in pregnancy, and close plasma glucose control of any woman with abnormal glucose levels, (which is now the WHO definition of gestational diabetes). It was interesting that the Ethics committees approved not telling the control participants that they had carbohydrate intolerance (which was subsequently defined as gestational diabetes). In fact, they included some women with normal glucose levels in the management of the control group so they would not suspect they had abnormal glucose levels.

25-316 Gestational diabetes mellitus – time to treat.

Greene MF, Solomon CG. N Engl J Med. 16 June 2005. Vol.352. No.24. p.2544-6.

Reviewed by Dr Raina Elley

Review: This editorial discusses the inconsistent evidence around screening and treatment of gestational diabetes (carbohydrate intolerance first recognised in pregnancy) and the possible reasons for this. The cut-off of when it would be beneficial to treat is also uncertain. The authors think that the ACHOIS trial demonstrates clearly the benefits of screening high-risk women and tight glucose control. They also believed that the lack of treatment of the control women was ethical, considering the mixed evidence about benefit, the fact that this approach mimicked real management in some centres and that the issue needed to be clarified. (See 25-315)

Oncology

25-317 Antioxidants don't prevent GI cancers and increase overall mortality.

J Fam Pract. January 2005. Vol.54. No.1. p.13.

Reviewed by Dr Bruce Adlam

Review: This Cochrane based meta-analysis of RCTs studying antioxidants in gastrointestinal cancers reveals some surprising results. Antioxidants do not prevent gastrointestinal cancers. In fact, in pooled results of high-quality studies, antioxidants increased overall mortality. (Level of evidence 1a) Antioxidants studied were beta-carotene, vitamins A, C, and E, and selenium, as different combinations or separately versus placebo. None of the supplements protected against oesophageal cancer, gastric cancer, colorectal cancer, or pancreatic cancer. In the high-quality studies, antioxidants increased overall mortality (8.0% versus 6.6%). This translates to a number needed to treat to harm of 69 for one additional death (95% confidence interval [CI], 58-85). (Original article reviewed: Lancet 2004; 364: 1219-28.)

Comment: Four trials of selenium (three with unclear or poor methodology) reduced the incidence of gastro-intestinal cancer (odds ratio=0.49; 95% CI, 0.36-0.67). Authors suggests selenium should be evaluated in randomised trials with sound methods.

Ophthalmology

25-318 Posterior vitreous detachment: How to approach sudden-onset floaters and flashing lights.

Margo CE, Harman LE. Postgrad Med. March 2005. Vol.117. No.3. p.37-42.

Reviewed by Dr Chris Milne

Review: Acute posterior vitreous detachment is the most common cause of unilateral floaters and flashing lights. These symptoms are frightening to patients, and they will usually present within a day or two. Our job is not to miss treatable pathology.

Comment: In general, the advice is to refer patients with such symptoms to an ophthalmologist for evaluation within the next 24 hours. Well written article with useful glossary of relatively obscure ophthalmology terms.

Physician-Patient Relations

25-319 Patient satisfaction affected by physician self-disclosure.

J Fam Pract. January 2005. Vol.54. No.1. p.16, 19.

Reviewed by Dr Bruce Adlam

Review: Self-disclosure – that is, sharing a personal story with patients – is perceived favourably by patients of surgeons but less so by patients of primary care physicians. In this nonrandomised study in which physicians occasionally self-disclosed, patients' perceptions of their physician's warmth and friendliness, reassurance and comfort, and their degree of satisfaction with their visit increased with disclosure by surgeons but decreased with disclosure by primary care physicians. (Level of evidence =2b) (Original article reviewed: J Gen Intern Med 2004; 19: 905-10).

Preventive Medicine and Screening

25-320 Reliability and validity of a brief physical activity assessment for use by family doctors.

Marshall AL, Smith BJ, Bauman AE, et al. Br J Sports Med. 1 May 2005. Vol.39. No.5. p.294-7.
Reviewed by Dr Chris Milne

Review: This assessment contained two questions – 1. How many times a week do you usually do 20 minutes of vigorous physical activity that makes you sweat or puff and pant? 2. How many times a week do you usually do 30 minutes of moderate physical activity or walking that increases your heart rate or makes you breathe harder than usual? The responses to the questions were then scored. Comparisons between assessments by doctors and research assistants showed a reasonably high correlation (70-80% agreement).
Comment: This study describes a practical tool that could be used by GPs or practice nurses to assess who is likely to be a good candidate for a Green Prescription.

Psychiatry and Psychology

25-321 The many faces of bipolar disorder: How to tell them apart.

Citrome L, Goldberg JF. Postgrad Med. February 2005. Vol.117. No.2. p.15-23.
Reviewed by Dr Chris Milne

Review: Bipolar disorder is split into two types – type 1 where manic episodes are accompanied by some depressive episodes, and type 2 where depressive symptoms predominate, but there is at least one hypomanic episode. It is important to recognise the condition because only 43% of patients in one large study regained their premorbid occupational and residential status. (See 25-322)
Comment: Useful article on an important condition.

25-322 Latest therapies for bipolar disorder: Looking beyond lithium.

Goldberg JF, Citrome L. Postgrad Med. February 2005. Vol.117. No.2. p.25-36.
Reviewed by Dr Chris Milne

Review: Beyond lithium, one can use anticonvulsant drugs (both the older and newer agents can act as mood stabilisers) plus newer antipsychotic agents e.g. olanzapine, respiridone or quetiapine. There have been remarkably few studies of combination therapy of lithium plus an anticonvulsant. (See 25-321)
Comment: The range of therapies has expanded fivefold from when I graduated in 1980. If you have a patient with labile mood disorder, get specialist advice.

25-323 Assessment and management of personality disorders.

Ward RK. Am Fam Physician. 15 October 2004. Vol.70. No.8. p.1505-12.
Reviewed by Dr Bruce Adlam

Review: A good summary of personality disorders. Such conditions are more common than we think in primary care. It gives specific advice for specific conditions. The article makes the point that these patients are as likely as anyone to develop major psychiatric problems which can make diagnosis difficult. The general advice is to establish clear boundaries, limit setting on patient's behaviour and medical resources and provision of reassurance when appropriate.
Comment: Good overview if you don't have one.

Public Health

25-324 Motor vehicle accidents during episodes of hypoglycaemia: Case reports and lessons to be learnt.

Diamond TH, Collins J, Rohl P. Aust Fam Physician. March 2005. Vol.34. No.3. p.151-4.
Reviewed by Dr Rachel Monk

Review: Based around five cases this article discusses factors about diabetes, particularly hypoglycaemic episodes, when driving. There is definite legislation around this and although NZ's may be slightly different to Australia's it is well worth a read.

Respiratory System

25-325 Rhinosinusitis: what is the desired outcome?

Merenstein D. Am Fam Physician. 1 November 2004. Vol.70. No.9. p.1642, 45.
Reviewed by Dr Bruce Arroll

Review: An opinion piece, which discusses the issue of sinusitis like symptoms, associated with an upper respiratory tract infection. The author makes the point that most of them do not have bacterial sinusitis and that antibiotics are not indicated for these conditions. He makes the point that just as in the acute treatment of acute otitis media, antibiotics are no longer the first choice treatment option. See also 25-326 and 25-327.
Comment: It is good to see such a clear article advocating a cautious approach to antibiotics.

25-326 Acute bacterial rhinosinusitis in adults: Part 1: Evaluation.

Scheid DC, Hamm RM. Am Fam Physician. 1 November 2004. Vol.70. No.9. p.1685-92.
Reviewed by Dr Bruce Arroll

Review: See 25-325and 25-327.

25-327 Acute bacterial rhinosinusitis in adults: Part II. Treatment.

Scheid D, Hamm RM. Am Fam Physician. 1 November 2004. Vol.70. No.9. p.1697-704.
Reviewed by Dr Bruce Arroll

Review: See 25-325 and 25-326. The Sinus Infections patient handout is attached.

25-328 Answering a question about the treatment of croup.

Hiramanek N. Aust Fam Physician. March 2005. Vol.34. No.3. p.171.
Reviewed by Dr Rachel Monk

Review: Steroids or not in mild croup? What does the evidence say?
Comment: Will you be changing the way you manage mild croup after reading this short article?

Smoking

25-329 Smoking cessation, lung function, and weight gain: a follow-up study.

Chinn S, Jarvis D, Melotti R, et al. Lancet. 7-13 May 2005. Vol.365. No.9471. p.1629-35.
Reviewed by Dr Tony Hanne

Review: In a multi-centre European study of those who quit smoking, the decline in FEV1 over eight years was followed in more than 6000 people. As expected, the decline was less in quitters than in smokers. There was no significant gender difference. What was of particular interest was the effect of weight gain in the same patients. This also caused a further decline of FEV1 proportional to the amount of weight gain. In men the effect of weight gain was to cancel 38% of the benefit of quitting in men and 17% in women.

Comment: It appears that the fear of weight gain if smoking is stopped is justifiable not only on cosmetic grounds but because of its effect on lung function. This study highlights the value of a whole lifestyle improvement goal. Driving smokers out of restaurants onto the pavement is not the whole answer. See also 25-330.

25-330 Smoking cessation, weight gain, and lung function.

Colditz G, Stein C. Lancet. 7-13 May 2005. Vol.365. No.9471. p.1600-1.
Reviewed by Dr Tony Hanne

Review: The accompanying editorial for the article on smoking cessation and weight gain in the same issue – see 25-329.

Sports and Sports Medicine

25-331 Management of ankle sprains: a randomised controlled trial of the treatment of inversion injuries using an elastic support bandage or an Aircast ankle brace.

Boyce SH, Quigley MA, Campbell S. Br J Sports Med. 1 February 2005. Vol.39. No.2. p.91-6.
Reviewed by Dr Chris Milne

Review: This study, based in two hospital A&E departments, showed that use of an Aircast brace for the treatment of lateral ligament ankle sprains produced a significant improvement in ankle joint function at 10 days and one month post injury, compared with standard treatment with an elastic support bandage

Comment: Not everybody needs to have one of these braces. They should be reserved for those with a positive anterior drawer test or positive talar tilt test, as these are the people with complete lateral ligament ruptures.

25-332 Eccentric decline squat protocol offers superior results at 12 months compared with traditional eccentric protocol for patellar tendinopathy in volleyball players.

Young MA, Cook JL, Purdam CR, et al. Br J Sports Med. 1 February 2005. Vol.39. No.2. p.102-5.
Reviewed by Dr Chris Milne

Review: These authors are well recognised for previous contributions to our understanding of management of tendinopathy. They have added a further refinement. The somewhat long-winded title explains the results very well. Most athletes could continue to train and play with pain.

Comment: Patellar tendinopathy is endemic amongst volleyballers and basketballers – hence its common name of jumper's knee. This protocol now becomes world best practice for the treatment of jumper's knee.

25-333 From catastrophe to complexity: a novel model of integrative central neural regulation of effort and fatigue during exercise in humans: summary and conclusions.

Noakes Td, St Clair Gibson A, Lambert EV. Br J Sports Med. 1 February 2005. Vol.39. No.2. p.120-4.
Reviewed by Dr Chris Milne

Review: Traditional teaching is that peripheral fatigue is the limiting factor in high level exercise. These experts lay out a detailed rebuttal of that teaching and propose an alternative model. They postulate a 'central governor' – in effect, our brain puts the brakes on when we exercise too hard.

Comment: An elegantly argued thesis from well respected original thinkers from South Africa. If you have any more than a passing interest in peak sports performance, you will find this fascinating – and a must-read article.

25-334 Return to play guidelines after anterior cruciate ligament surgery.

Myklebust G, Bahr R. Br J Sports Med. 1 March 2005. Vol.39. No.3. p.127-31.
Reviewed by Dr Chris Milne

Review: Most ACL reconstructions are performed for people who have recurrent instability, and wish to return to playing multidirectional sport. These authors ask the crucial question – should they return to such activities? Performing a reconstruction improves the odds of returning to the preinjury level of activity from 58% to 82%.

Comment: In 1970, Jack Kennedy stated that 'the ACL is the most common cause of the ex- athelete'. This thankfully is no longer the case, but it may yet prove to be the major cause of the limping ex-athlete.

25-335 Scale of protection and the various types of sports mouthguard.

Patrick DG, van Noort R, Found MS. Br J Sports Med. 1 May 2005. Vol.39. No.5. p.278-81.
Reviewed by Dr Chris Milne

Review: This paper analyses the protection offered by stock mouthguards, mouth formed mouthguards and custom made mouthguards. Not surprisingly, the custom made mouthguards provided the best protection. The authors suggest a grading system from one to 10 that enables easy assessment of the protection they provided.

Comment: Ideally, all players should wear custom made devices. This pa-

per is a worthwhile contribution to the literature.

25–336 A prospective study of injuries and training amongst the England 2003 Rugby World Cup squad.

Brooks JH, Fuller CW, Kemp SP, et al. Br J Sports Med. 1 May 2005. Vol.39. No.5. p.288-93.

Reviewed by Dr Chris Milne

Review: This study analysed the injuries occuring to England rugby team players at training sessions and in games. Endurance running and contact (they mean collision) training represented the highest risk activities. Overall injury incidence was 17 injuries per 1000 hours of exposure (218 per 1000 hours in games, 6.1 per 1000 hours in training).

Comment: The incidence of game injuries at international level is higher than previously reported. This paper is a useful addition to the literature.

25–337 Summary and agreement statement of the 2nd International Conference on Concussion in Sport, Prague 2004.

McCrory P, Johnston K, Meeuwisse W, et al. Br J Sports Med. 1 April 2005. Vol.39. No.4. p.196-204.

Reviewed by Dr Chris Milne

Review: This conference of world experts updated the guidelines from the 2001 conference in Vienna. Two major innovations were the specific recommendations for children (we should err on the side of caution in returning them to train or play, and this should wait until they are completely symptom free). In addition, children should limit their time at school (cognitive rest) and exertion while they are symptomatic following concussion. The other major advance was the distinction between simple concussion, that resolves within seven to 10 days, and complex concussion, where symptoms linger on. Our resources should be concentrated on those athletes with complex concussion, and multi-disciplinary management is desirable.

Comment: If you read one article on concussion in the next three years, it should be this one! Then look out for the next consensus conference report. See also 25-338.

25–338 Summary and agreement statement of the Second International Conference on Concussion in Sport, Prague 2004.

McCrory P, Johnston K, Meeuwisse W, et al. Physician and Sportsmedicine. April 2005. Vol.33. No.4. p.29-44.

Reviewed by Dr Rob Campbell

Review: This 2004 Symposium was a follow-up of the 2001 symposium which was the first such symposium. The aims were to provide recommendations for the safety and health of athletes who were concussed. It addressed specific issues of epidemiology, basic and clinical science, injury grading systems, cognitive assessment, new research methods, protective equipment, management, prevention, and long term outcome.

Comment: The Gold Standard and should be read by those caring for concussed patients. See also 25-337.

25–339 Primary care of the sports hernia: Recognizing an often-overlooked cause of pain.

Johnson JD, Briner WW. Physician and Sportsmedicine. February 2005. Vol.33. No.2. p.35-9.

Reviewed by Dr Rob Campbell

Review: Sports hernia is a term used to describe a syndrome of groin pain, without a clinically detectable hernia due to disruption of the posterior inguinal wall. There may be coexisting pathology (e.g. osteitis pubis) but the inguinal wall damage is best treated with surgery in the athlete.

Comment: A useful description of an often difficult clinical presentation.

25–340 Acute lumbar disk injuries in active patients: Making optimal management decisions.

Lively MW, Bailes JE. Physician and Sportsmedicine. April 2005. Vol.33. No.4. p.21-7.

Reviewed by Dr Rob Campbell

Review: This article focusses on the management of acute disc protrusions specifically, rather than a broad approach to back pain. It explores the research data on most available treatments including interventions such as corticosteroid injections, chemonucleolysis and surgery.

Comment: The science suggest 90% will recover without surgery: the art is getting them through the initial four to six weeks. A useful paper to guide your approach.

25–341 Facial injuries in sports: A team physician's guide to diagnosis and treatment.

Romeo SJ, Hawley CJ, Romeo MW, et al. Physician and Sportsmedicine. April 2005. Vol.33. No.4. p.45-53.

Reviewed by Dr Rob Campbell

Review: This article explores the abrasions, lacerations, fractures, haematomas, ear traumas, and facial bone fractures seen in sport. It is a reasonably in depth look at these injuries and points out the pitfalls and 'not to be missed' injuries.

Comment: This is an excellent practical paper with some pertinent clinical tips, both for diagnosis and management. A worthy read for team doctors.

25–342 High hamstring tendinopathy in runners: Meeting the challengers of diagnosis, treatment, and rehabilitation.

Fredericson M, Moore W, Guillet M, et al. Physician and Sportsmedicine. May 2005. Vol.33. No.5. p.32-43.

Reviewed by Dr Rob Campbell

Review: A difficult clinical presentation for all clinicians as these are typical of tendinosis and entheseopathies (i.e. there is no quick fix). This paper explores the anatomy, biomechanics, examination findings and management of this problem.

Comment: A well worthwhile article with good diagrams and encourages a long-term rehabilitation approach which is usually successful.

25–343 Does quinine reduce leg cramps for young athletes.

Robertson M, Hale W, Mackler L. J Fam Pract. January 2005. Vol.54. No.1. p.76-8.
Reviewed by Dr Bruce Adlam

Review: Very little evidence exists regarding the use of quinine for cramps in young adult athletes. Quinine may be an effective treatment for heat cramps in athletes (strength of recommendation C). Quinine is better established as an effective treatment for nocturnal leg cramps in the general adult population (strength of recommendation A).

Comment: Our sports physicians will be able to advise on this, however, the commentary following this article suggests hydration before, during, and after activity remains the cornerstone to approaching cramping in athletes. Appropriate salt intake for those who lose high concentrations of salt in their sweat may also be useful in prophylaxis. Once cramps occur, rehydration, stretching, massage, and rest work best.

Therapeutics

25-344 The power of placebo.

McCrory P. Br J Sports Med. 1 March 2005. Vol.39. No.3. p.125.
Reviewed by Dr Chris Milne

Review: A recent prospective RCT of magnetic bracelets showed that they were equally as effective as dummy (placebo) bracelets in relieving the pain of osteoarthritis of the hip or knee in 194 subjects.

Comment: As the reviewer states – in this era of evidence-based medicine, it is reassuring to know that placebos still work!

25-345 What is the addiction risk associated with tramadol?

McDiarmid T, Mackler L. J Fam Pract. January 2005. Vol.54. No.1. p.72-3.
Reviewed by Dr Bruce Adlam

Review: Tramadol carries a risk of substance abuse (strength of recommendation B). While it appears the risk is low, tramadol is associated with a withdrawal syndrome usually typical of opioid withdrawal.

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

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

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

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