Journal Review Service

Continuing Medical Education in General Practice from the Goodfellow Unit

Journals Reviewed in this Issue

Acupunct Electrother Res*
Aust Fam Physician*
BMJ*
Br J Sports Med*
Brain Res*
Can Fam Physician Med Fam Can*
Clin J Pain*
Evidence-Based Medicine*
Int J Urol*
J Fam Pract*
Lancet*
N Engl J Med*
Obes Res*
Physician and Sportsmedicine*
Postgrad Med*
Sci Am*
*Journals indexed in Medline

Acupuncture

25-001 Relieving effects of electroacupuncture on mechanical allodynia in neuropathic pain model of inferior caudal trunk injury in rat: mediation by spinal opioid receptors.

Kim, JH, Min BI, Na HS, et al. Brain Res. 20 February 2004. Vol.998. No.2. p.230-6.
Reviewed by Dr Alex Chan

Review: The effect and optimal frequency of electroacupuncture (EA) on mechanical allodynia were investigated in a rat model of neuropathic pain. Trained pulses of 2 or 100 Hz were applied to needles inserted into ST-36 for 30 minutes. For the control, needles were inserted at the same location without electrical stimulation. 2 Hz EA produced significant and longer lasting analgesic effects than 100 Hz. This analgesic effect could be blocked by spinal intrathecal injection of mu- and delta-opioid antagonists but not by kappa-antagonist, indicating that the mu- and delta opioid receptors in the spinal cord played a significant role in mediating the relieving effect of EA in mechanical allodynia.

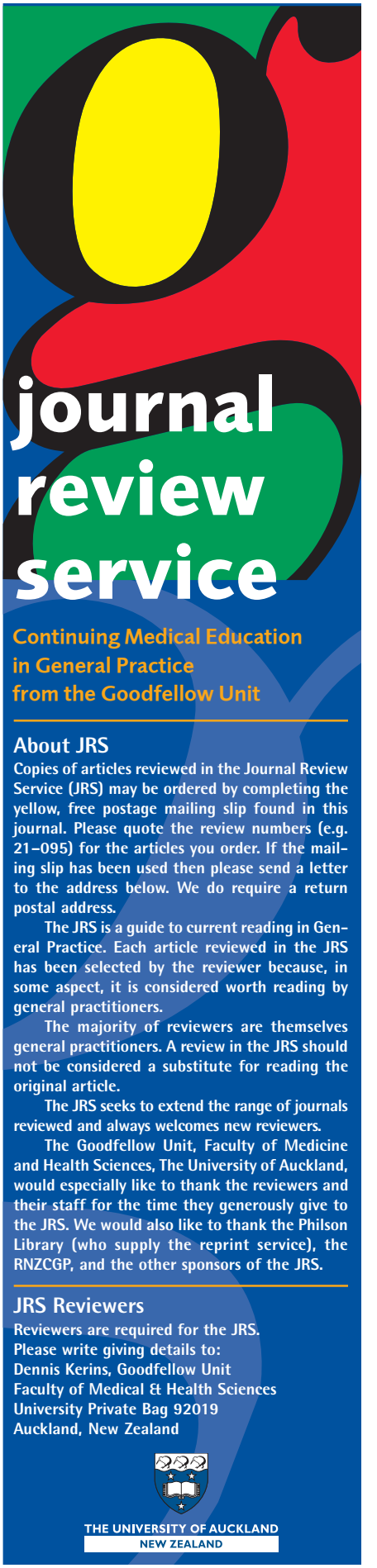
Comment: Note that previously low frequency EA has been shown to be effective clinically in nociceptive pain states, while high frequency stimulation is more effective in neuropathic pain, which is in contrast to this animal model.

25-002 Statistical reanalysis of four recent randomized trials of acupuncture for pain using analysis of covariance.

Vickers AJ. Clin J Pain. September/October 2004. Vol.20. No.5. p.319-23.
Reviewed by Dr Alex Chan

Review: Many randomised acupuncture trials have been criticised for deficiencies of methodology, acupuncture technique, and sample size. This article concentrated on critiquing methods of statistical analysis as a source of incorrect analysis in four trials of acupuncture for musculoskeletal or headache pain. The trials had been criticised of suboptimal power. The author found that the statistical methods used did not adjust for baseline pain scores. The original raw data from these trials were reanalysed using analysis of covariance (ANCOVA). Interesting results favouring acupuncture in these trials were obtained.

Comment: This confirmed the importance of consulting a good and unbiased statistician during the design stage of research as well as when making evidence-based recommendations.



25-003 Effects of acupuncture for chronic pelvic pain syndrome with intrapelvic venous congestion: preliminary results.

Honjo J, Kamoi K, Naya Y, et al. Int J Urol. August 2004. Vol.11. No.8. p.607-12.

Reviewed by Dr Alex Chan

Review: The effect of acupuncture on non-inflammatory chronic pelvic pain syndrome with intrapelvic venous congestion was measured in 10 male patients. Manual acupuncture was performed at BL-33 points bilaterally and weekly for five weeks. The results were assessed on the 6th week by NIH chronic prostatitis symptom index (NIH-CPSI) and the international prostate symptom score (IPSS), transrectal ultrasonography (TRUS) and magnetic resonance (MR) venography. All showed significant improvement. It is interesting to point out that in eight of the participants, previous trials with medical therapies including antibiotics, anti-inflammatories and cernitin pollen extract were unsuccessful.

Comment: This is only a report from a pilot study and not a blinded trial. There was no control group or placebo group. However, it showed that acupuncture could be an option for those who have not responded to conventional therapies.

25-004 The effect of acupuncture on alpha-motoneuron excitability.

Chan AK, Vujnovich A, Bradnam-Roberts L. Acupunct Electrother Res. 2004. Vol.29. No.1-2. p.53-72.

Reviewed by Dr Alex Chan

Review: The effect of short duration and sustained manual acupuncture at the acupuncture points GB-34 and SP-9 on alpha-motoneuron excitability was studied using the Soleus H-reflex. Sustained manual acupuncture caused significant reduction of alpha-motoneuron excitability, while short duration manual acupuncture had no effect. The reduction of alpha-motoneuron excitability following sustained manual acupuncture occurred fifteen minutes after cessation of acupuncture and was still present at 30 minutes. The relationship between perceived intensity of acupuncture sensation (Deqi) and changes in alpha-motoneuron excitability was also studied, but no significant correlation was found.

Comment: A New Zealand contribution to acupuncture research. Manual acupuncture would be useful in clinical conditions associated with increased alpha-motoneuron excitability. When using acupuncture for these conditions, higher intensity of perceived acupuncture sensation (Deqi) may not result in greater degree of reduction in alpha-motoneuron excitability. (Note: The reviewer of this article is also one of the authors – Editor)

Alcohol and Substance Abuse

25-005 The growing challenge of party drugs in general practice.

Khong E, Wain T. Aust Fam Physician. September 2004. Vol.33. No.9. p.709-13.

Reviewed by Dr Rachel Monk

Review: Good summary about party drugs. Includes a list of drugs with 'street names' and how each is used, along with its main effects. Comes with suggestions of what the GP can do to help.

Comment: Suitable for all GPs given the increasing problems with party drugs in NZ too.

Analgesia

25-006 Changing the face of pain management: Mechanism-based treatment most likely to succeed.

Levin M. Postgrad Med. September 2004. Vol.116. No.3. p.45-48.

Reviewed by Dr Chris Milne

Review: Patients with chronic pain are common, and tend to consume large amounts of consulting time and medical resources. It is important early on to get a clear idea of whether the patient has nociceptive path (usually acute aching, stabbing) or neuropathic (burning pain with allodynia). This then determines the most appropriate treatment.

Comment: There are a few 'failed neck' or 'failed back' patients in most general practices. It is important to seek the assistance of a multidisciplinary pain clinic for these people.

Asthma

25-007 Peak expiratory flow rate does not predict asthma exacerbations.

J Fam Pract. August 2004. Vol.53. No.8. p.608.

Reviewed by Dr Bruce Adlam

Review: Routine measurement of peak expiratory flow rate does not predict subsequent asthma exacerbations. Therefore, routine measuring of lung function in this way is not useful.

(Original article reviewed: J Gen Intern Med 2004; 19:237-242.)
Comment: In this study, a PEFR of less than 50% at baseline predicted an exacerbation over the following 12 months, but PEFR change was not a better independent predictor than quality-of-life scores. By contrast, the quality-of-life scores were independently predictive of an exacerbation at both four months and 12 months.

Cardiovascular System

25-008 Does combining aspirin and warfarin decrease the risk of stroke for patients with nonvalvular atrial fibrillation?

Robertson SL, Mayer JB. J Fam Pract. July 2004. Vol.53. No.7. p.570, 72,75.
Reviewed by Dr Bruce Adlam
Review: Adjusted-dose warfarin (international normalised ratio [INR]=2.0–3.0) remains the most efficacious antithrombotic regimen for the primary and secondary prevention of cardio-embolic stroke in high-risk patients with nonvalvular atrial fibrillation (NVAF) (SOR: A). Aspirin therapy at a dose of 75 to 325mg reduces the risk of stroke to a lesser degree and may be useful for low-risk patients with NVAF or patients at high risk for bleeding (SOR: A). Combination therapy with low, fixed-dose warfarin (1–2 mg) and aspirin has not been shown to be superior to aspirin therapy alone. Moreover, this combination appears to be inferior to adjusted-dose warfarin (SOR: A). To date, no clinical trials have investigated the efficacy and safety of combining adjusted-dose warfarin and aspirin for the prevention of stroke from NVAF.
Comment: One of several good articles on the same theme. (See also 25-009, 25-010 and 25-011.) Also includes good summary table for stroke prevention strategies.

25-009 Statins prevent strokes in high-risk patients.

Anonymous. J Fam Pract. July 2003. Vol.53. No.7. p.522.
Reviewed by Dr Bruce Adlam
Review: See 25-008, 25-010 and 25-011.

25-010 Other than anticoagulation, what is the best therapy for those with atrial fibrillation?

Cadwallader K, Jankowski TA. J Fam Pract. July 2004. Vol.53. No.7. p.581-3.
Reviewed by Dr Bruce Adlam
Review: Rate control with long-term anticoagulation is recommended for most patients with atrial fibrillation (SOR: A). A rhythm-control strategy provides no survival or quality-of-life benefit when compared with rate control and causes more adverse drug effects and increased hospitalisations (SOR: A).
Comment: The atrial fibrillation evidence also suggests that we need to place beta-blocker and non-dihydropyridine calcium-channel blockers (i.e. verapamil and diltiazem) as first-line choices for rate-control therapy. Digoxin still has a place but these authors feel its role is as an adjunct or backup to the blockers for most patients. (See also 25-008, 25-009 and 25-011.)

25-011 What is the best therapy for superficial thrombophlebitis?

Neher JO, Safranek SM. J Fam Pract. July 2004. Vol.53. No.7. p.583-5.
Reviewed by Dr Bruce Adlam
Review: For proximal saphenous vein thrombosis, anticoagulation is more effective than venous ligation (with or without stripping) in preventing deep venous thrombosis (DVT) and pulmonary embolus (SOR: C, qualitative systematic review of primarily case series). For patients with superficial venous thrombophlebitis distal to the saphenous vein of the thigh, tenoxicam (a NSAID) and low-molecular-weight heparin are similarly effective for reducing extension and subsequent DVT when administered along with compression therapy (SOR: B). Oral or topical NSAIDs, topical heparin, and topical nitroglycerin all alleviate symptoms and speed resolution of SVTP caused by infusion catheters (SOR: B smaller, occasionally conflicting randomized trials). (See also 25-008, 25-009, and 25-010.)

25-012 Does moderate exercise prevent MI for patients with coronary heart disease?

Riedel R, Kelsberg G, Greenley S. J Fam Pract. July 2004. Vol.53. No.7. p.585-6.
Reviewed by Dr Bruce Adlam
Review: Moderate exercise reduces mortality for patients with known coronary heart disease but does not significantly decrease the risk of recurrent nonfatal myocardial infarction (MI) (SOR: A). Exercise-based cardiac rehabilitation also reduces all-cause mortality. There are some limitations in these studies, not the least being the rather small size of the studies examined. The population appears skewed towards males under the age of 65 and there are criticisms regarding randomisation and high rates of loss to follow-up.
Comment: Given this, for patients with stable angina, a daily exercise programme is more effective than percutaneous transluminal coronary angioplasty (PTCA) with stenting in preventing major cardiovascular events (number needed to treat [NNT]=5.5; (SOR: A).

25-013 Rebuilding broken hearts.

Cohen S, Leor J. Sci Am. November 2004. Vol.291. No.5. p.44-51.
Reviewed by Dr Ron Vautier
Review: Tissue engineers are exploring how to produce a piece of myocardium in vitro by seeding a porous polymer matrix with appropriate undifferentiated cells and growth factors. This could then be used to surgically replace the scar that results from an infarct.
Comment: Somewhat fascinating, and possibly not very many years in the future before clinical application starts.

25-014 Angiotensin receptor blockers and myocardial infarction.

Verma S, Strauss M. BMJ. 27 November 2004. Vol.329. No.7477. p.1248-9.
Reviewed by Dr Len Brake
Review: There could be something dodgy about the angiotensin receptor blockers. This editorial is a comment on the increase in myocardial infarction in patients using valsartin in the VALUE trial reported in the Lancet. Also looks at the CHARM study where, despite lowering BP, candesartan did not prevent death.
Comment: These disturbing effects stand in contrast to the ACE inhibitors, which consistently produce a 20% or greater reduction in myocardial infarction.

25-015 Six monthly scheduled follow up of hypertension was equivalent to three monthly scheduled follow up.

Feder G. Evidence-Based Medicine. September/October 2004. Vol.9. No.5. p.138.
Reviewed by Dr Bruce Arroll
Review: This was an RCT in Canada which randomised patients to either three-month or six-month follow-ups. At one, two and three years there was no difference in the proportion who were considered out of control, as defined by each family practitioner (between 16% and 18% at three years). (Original article reviewed: BMJ 2004; 328: 204-9)
Comment: Under the PHO environment, seeing patients less often for monitoring elevated blood pressure may be worth considering.

25-016 High dose atorvastatin was superior to standard dose pravastatin in reducing death or major CV events in acute coronary syndrome.

Hillegass WB, Alam GK. Evidence-Based Medicine. September/October 2004. Vol.9. No.5. p.144.
Reviewed by Dr Bruce Arroll
Review: This study was a randomised trial of Atorvastatin 80mg versus 40mg of Pravastatin in patients with acute coronary syndrome. The Atorvastatin reduced a composite cardiovascular endpoint with an NNT of 19 when compared with Pravastatin. The target LDL cholesterol level was 1.8 mmol/l. (Original article reviewed: N Engl J Med 2004; 350: 1495-504)
Comment: The commentator stated that in acute coronary syndromes we should aim for LDL cholesterol levels of 1.8 mmol/l. It seems as if there is no lower limit for LDL that does not confer some benefit.

25-017 Chest radiographs and BNP levels provided complementary information beyond clinical findings for diagnosing heart failure.

Henriksson P. Evidence-Based Medicine. September/October 2004. Vol.9. No.5. p.152.
Reviewed by Dr Bruce Arroll
Review: This study was a blinded comparison of chest radiograph and BNP with a confirmatory clinical diagnosis. It found that cardiomegaly, cephalisation and interstitial oedema were increasingly good chest x-ray signs of heart failure. The BNP was a good rule in of CHF as it became higher (> 300 pg/ml) and that at lower levels (<100 pg/ml) was good at ruling out CHF. (Original article reviewed: Am J Med 2004: 116: 363-8)
Comment: The commentator makes the point that both chest x-ray and BNP are useful in making a rule in or rule out diagnosis of heart failure.

25-018 Angiotensin-converting-enzyme inhibition in stable coronary artery disease.

The PEACE Trial Investigators. N Engl J Med. 11 November 2004. Vol.351. No.20. p.2058-68.
Reviewed by Dr Raina Elley
Review: ACE inhibitors have been shown to reduce cardiovascular events and death amongst those with congestive heart failure and amongst those with coronary artery disease (CAD) in the presence of reduced left ventricular (LV) function. This double blind RCT tested the hypothesis that there may be benefit for those with CAD without impaired LV function. 8290 people >50 years with stable CAD participated with half receiving trandolapril 4mg/day and half placebo. This study population had already had aggressive management with 72% having had coronary revascularisation, 70% on lipid lowering therapy and a mean LV ejection fraction of 58% +/-9%. The average age was 64 and the average BP 133/78. With a mean follow-up of 4.8 years there was no significant reduction in primary endpoints, cardiovascular death, myocardial infarction or cardiac revascularisation, despite a greater reduction in blood pressure, lower rates of development of diabetes and hospitalisation for CHF in the trandolapril group.
Comment: The authors conclude that there is no extra benefit in terms of cardiovascular death or myocardial infarction of adding an ACE inhibitor to the medication regime of a well-controlled person with stable CAD and no substantial LV dysfunction. However, the very low rates of cardiac death or MI in both groups in this study remind us of the importance of tight control of lipids and blood pressure in those with pre-existing CAD.

25-019 Outpatient treatment of recent-onset atrial fibrillation with the 'pill-in-the-pocket' approach.

Alboni P, Bott GL, Baldi N, et al. N Engl J Med. 2 December 2004. Vol.351. No.23. p.2384-91.
Reviewed by Dr Raina Elley
Review: Recurrent atrial fibrillation is usually managed by prophylactic oral anti-arrhythmic therapy. This study assessed the feasibility and safety of using a single self-administered dose of flecainide or propafenone (both Class 1C anti-arrhythmics of equivalent efficacy and safety). 210 patients (mean age 59 years) with recurrent atrial fibrillation with no or mild CHF and who had responded previously to oral flecainide or propafenone to convert their AF to sinus rhythm in the Emergency Department (ED) were given further single doses of flecainide or propafenone as a 'pill-in-the-pocket'

to self-administer whenever they developed palpitations. Occurrence of palpitations, self-administration of medication, and resolution of symptoms were recorded by self-report over an average of 15 months. 618 episodes of arrhythmia experienced by 165 participants, occurred. 569 (92%) were treated with the 'pill-in-the-pocket' an average of 36 minutes after onset, with treatment being 'successful' in 534 (94%) cases. 7% reported adverse effects, including atrial flutter in one case, a known side-effect of these anti-arrhythmic drugs. The numbers of visits to ED or hospital were significantly lower than during the previous year for participating individuals.

Comment: It may be concluded that this approach is feasible, apparently safe, and achieved good compliance, as an alternative to continuous oral prophylaxis amongst a select group with recurrent AF. However, this was not a randomised controlled trial. Even though they used historical controls (the same participants the year before) to compare hospital and ED visits, this is a less rigorous approach than to randomise and compare prospectively between groups (e.g. single dose versus continuous prophylaxis: it would be impossible to ethically justify single dose versus placebo). In addition, the episodes of 'arrhythmia' were self-reported episodes of palpitations, not ECG documented AF. Resolution of 'arrhythmia' was also self-reported. Therefore, these findings are less reliable (of resolution of AF with self-administration of flecainide or propafenone single dose), than if objective outcome measures were used. Even so, this is a promising finding and more studies, preferably RCTs, of efficacy and safety are warranted.

25-020 Newly diagnosed atrial fibrillation.

Page RL. N Engl J Med. 2 December 2004. Vol.351. No.23. p.2408-16.

Reviewed by Dr Raina Elley

Review: This clinical practice review is very good and presents some interesting facts as well as the rationale behind using different treatment regimes. For example, those with intermittent AF are at the same increased risk of stroke as those with continuous AF. Tables of appropriate anti-thrombotic treatment and rate-controlling therapy according to American Heart Association – American College of Cardiologists guidelines and according to the American College of Chest Physicians guidelines (which differ) are presented. The justification for differing approaches for different groups of patients is well set out. The rationale for the shift from Digoxin to B-blocker or Ca Channel blocker therapy is discussed, as are the target resting and exercise heart rates. In addition, the article discusses rate versus rhythm control, with current evidence showing no difference in terms of quality of life, stroke or mortality.

Comment: A thorough review, which takes a very practical approach. Even though American guidelines and management are referenced, the rationale for management is interesting and just as relevant for our practice.

Cerebrovascular System

25-021 Cholesterol lowering with simvastatin reduced stroke in patients with, or at risk of, vascular disease.

Johnston SC. Evidence-Based Medicine. September/October 2004. Vol.9. No.5. p.143.

Reviewed by Dr Bruce Arroll

Review: This large RCT of 40mg of simvastatin daily in patients at high risk of vascular disease found a reduction in stroke with an NNT of 71 to prevent one new stroke. (Original article reviewed: Lancet 2004; 3363: 757-67)

Comment: The commentator suggested that it is worth giving a statin to all who can tolerate them after a thrombolic stroke or transient ischaemic attack.

Dermatology

25-022 Why am I so itchy?

Clarke P. Aust Fam Physician. July 2004. Vol.33. No.7. p.489-94.

Reviewed by Dr Rachel Monk

Review: Nice little reminder about a couple of common causes of itch (eczema and scabies), as well as less common causes to bear in mind, (dermatitis herpetiformus and lichen planus). Brief information on aspects of history, examination and treatment but obviously not at textbook level.

Comment: Good starting point – might spin you off in another direction to track down more information.

25-023 Itch: a symptom of occult disease.

Hiramanek N. Aust Fam Physician. July 2004. Vol.33. No.7. p.495-9.

Reviewed by Dr Rachel Monk

Review: Good summary of systemic causes of itch (including cancer), illustrated by some case histories. Provides some useful tables to guide initial assessment and investigations as well as treatment.

Comment: Suitable for all to read.

25-024 Urticaria.

Clarke P. Aust Fam Physician. July 2004. Vol.33. No.7. p.501-3.

Reviewed by Dr Rachel Monk

Review: Brief but useful information on a relatively common problem. Includes possible triggers to ask about, for both acute and chronic urticaria. Also suggests a management plan for chronic uritcaria.

Comment: Useful for all GPs.

25-025 Vulval itch.

Welsh B, Howard A, Cook K. Aust Fam Physician. July 2004. Vol.33. No.7. p.505-10.

Reviewed by Dr Rachel Monk

Review: Nice discussion on the common causes of vulval irritation. Good detail on options for managing recurrent vulvovaginal candidiasis. See also the patient information sheet on good vulval care on page 517 (included).

Comment: Useful for all GPs, especially those with a special interest in women's health (or if you have lots of female patients).

25-026 Pruritus ani.

Heard S. Aust Fam Physician. July 2004. Vol.33. No.7. p.511-3.
Reviewed by Dr Rachel Monk
Review: Very brief but helpful article on a common problem. More information would be helpful. You may choose to read some of the reference articles if this is of interest.
Comment: Likely that all GPs will run into this at regular intervals – useful.

25-027 Injecting drug use and skin lesions.

Sim MG, Hulse G, Khong E. Aust Fam Physician. July 2004. Vol.33. No.7. p.519-22.
Reviewed by Dr Rachel Monk
Review: Case based article on skin lesions associated with injecting drug use – both typical and atypical lesions mentioned. Includes criteria for substance dependence and discussion particularly related to amphetamin use.
Comment: Helpful for all GPs to be aware of this. Not all presentations of injecting drug use are 'typical'.

Emergency Medicine

25-028 Emergency treatment of dentoalveolar trauma: Essential tips for treating active patients.

Honsik KA. Physician and Sportsmedicine. September 2004. Vol.32. No.9. p.23-9?
Reviewed by Dr Rob Campbell
Review: This article describes the type of dental injuries including tooth fracture, subluxation, avulsion and socket injury in anatomical detail and then explores the diagnostic features and appropriate management.
Comment: If you are dealing with at risk sports people this is a good reference. Prevention, of course, is the best treatment.

25-029 What's in the doctor's bag?

Hiramanek N, O'Shea C, Lee C, et al. Aust Fam Physician. September 2004. Vol.33. No.9. p.714-20.
Reviewed by Dr Rachel Monk
Review: Helpful guide when considering what to put in a medical bag – essentials and other items. Drug list not so helpful as this contains those which are available free to doctors in Australia.
Comment: Useful for those starting out in general practice or more experienced GPs whose bag needs a revision.

Endocrinology

25-030 Newly diagnosed hypothyroidism.

Rehman HU, Bajwa TA. BMJ. 27 November 2004. Vol.329. No.7477. p.1271.
Reviewed by Dr Len Brake
Review: As usual a good one to file in the coffee break read. A concise reminder on examination, lab findings, and how to start treatment and monitor it. Also includes a list of which patients to refer.

25-031 Preventing microalbuminuria in type 2 diabetes.

Ruggenenti P, Fassi A, Ilieva AP, et al. N Engl J Med. 4 November 2004. Vol.351. No.19. p.1941-51.
Reviewed by Dr Raina Elley
Review: This is a very interesting randomised controlled trial assessing whether ACE inhibitors or Ca channel blockers, or both, can stop the development of micro-albuminuria in people with type 2 diabetes. 1204 participants were randomised to receive an ACE inhibitor (trandolapril 2mg/d) plus Ca channel blocker (verapamil sr 180mg/d); trandolapril (2mg/day) plus placebo; verapamil (sr 240mg/d) plus placebo; or placebo alone for three years. The target BP was 120/80mmHg. The results showed that an ACE inhibitor alone or in combination with a Ca channel blocker reduce the proportion developing microalbuminuria, but Ca channel blocker alone does not, when compared with placebo. No difference in serious adverse events between the groups. Microalbuminuria in Type 2 diabetes is seldom reversible, unlike for Type 1 diabetes. Microalbuminuria is the first sign of renal damage. 20–40% of microalbuminuria progresses to overt proteinuria and 10–50% of those with proteinuria develop chronic kidney disease requiring dialysis or transplantation. Furthermore, the risk of dying of cardiovascular disease trebles when someone with type 2 diabetes develops microalbuminuria.
Comment: It should be a priority to avoid development of microalbuminuria in people with diabetes. These results reinforce the fact that ACE inhibitors should be the medication of choice for BP control in people with type 2 diabetes and normal renal function, and that there should be a low threshold for treatment.

25-032 Angiotensin-receptor blockade versus converting-enzyme inhibition in type 2 diabetes and nephropathy.

Barnett AH, Bain SC, Bouter P, et al. N Engl J Med. 4 November 2004. Vol.351. No.19. p.1952-61.
Reviewed by Dr Raina Elley
Review: Although previous trials have demonstrated that angiotensin II-receptor blocker use in patients with type 2 diabetes and nephropathy have reduced progression to renal failure, there had not been a comparison of the protective effect with ACE inhibition, before. This multicentre double blind RCT of five years duration and 250 participants with type 2 diabetes and mild nephropathy compared an angiotensin II-receptor blocker (telmisartan 80mg/d) with enalapril (20mg/d). Although there was less deterioration in glomerular filtration rate in the enalapril group compared with the telmisartin group, this difference was not statistically significant. Therefore, the authors concluded that the renoprotective effect of telmisartin was not inferior to that of enalapril in people with type 2 diabetes and mild nephropathy.

Comment: This is useful information and also tells us that angiotensin II-receptor blockers are also not superior to ACE inhibitors in slowing progression to renal failure.

Ethics

25-033 A lesson from the third year.

Helms E. Lancet. 6 November 2004. Vol.364. No.9446. p.1727.
Reviewed by Dr Tony Hanne
Review: A doctor remembers his third year as a medical student in a public hospital in the United States. He was attached to a Chinese illegal immigrant, Mr L, aged 70, who spoke no English, had no money and was in renal failure. He was deeply affected by his patient's isolation and the system which did not treat him as a person. His recollections become the basis for a discussion of medical professionalism or ethics which require that at the very least we strive for the best care for our patient, informed consent and a patient-centred approach, and social equity which does not discriminate.
Comment: Eric Helms' concern is that we learn these principles as medical students and maintain them throughout our professional lives, despite the pressure from health managers and politicians that patients like Mr L spoil their budgets.

Evidence-Based Medicine

25-034 The effectiveness of five strategies for the prevention of gastrointestional toxicity induced by non-steroidal anti-inflammatory drugs: systematic review.

Hooper L, Brown TJ, Elliot RA, et al. BMJ. 23 October 2004. Vol.329. No.7472. p.948-57.
Reviewed by Dr Len Brake
Review: 112 randomised trials were included – a total of 74 666 participants. Five (yes FIVE) were judged to be a low risk of bias. 138 deaths and 248 serious GI events were reported overall. This interesting paper (and a very practical general practice issue) highlights the poor quality of data collection. For evidence-based medicine to have credibility the data must include for example the rare but important events such as death, CVA etc. The writers conclude that there is a case for large independently funded research into the NSAID/side effects/effectiveness with a multicentre trial of at least 12 months.

25-035 What has evidence-based medicine done for us?

Straus SE, Jones G. BMJ. 30 October 2004. Vol.329. No.7473. p.987-88.
Reviewed by Dr Len Brake
Review: This is one editorial from a theme issue on EBM. Good points are summarised. For one thing there are too many sources of data of varying quality resulting in confused messages. Then there is the issue of evidence favouring an intervention but health policy preventing this. Not to mention the legal question – could a doctor be considered negligent by the courts for not applying evidence-based guidance in decision-making?

Family Practice

25-036 Allowing spirituality into the healing process.

Kliewer S. J Fam Pract. August 2004. Vol.53. No.8. p.616-24.
Reviewed by Dr Bruce Adlam
Review: There are three balanced, interesting items in this issue on spirituality and medicine that you may want to read. (See also 25-037 and 25-038.)
Comment: A core comment by one of the authors is that the process of learning how to integrate medicine and spirituality is not an easy one, nor will it be accomplished without struggle. But it is a process vitally important for modern medicine. The issue truly is one of caring, both when cure is possible, and when it is not. It is a matter of focusing on part of what makes us truly human, and supporting a healing process that often transcends the biomedical agenda.

25-037 Principles to make a spiritual assessment work in your practice.

Lawrence RT, Smith DW. J Fam Pract. August 2004. Vol.53. No.8. p.625-31.
Reviewed by Dr Bruce Adlam
Review: See 25-036.

25-038 Is religious devotion relevant to the doctor-patient relationship?

Curlin FA, Moschovis PP. J Fam Pract. August 2004. Vol.53. No.8. p.632-6.
Reviewed by Dr Bruce Adlam
Review: See 25-036.

General

25-039 The search for a disease.

Hassed C. Aust Fam Physician. August 2004. Vol.33. No.8. p.641-2.
Reviewed by Dr Rachel Monk
Review: 'Are we creating diseases which aren't diseases?' is the question raised in this little article... menopause, ageing...are these 'diseases' or part of the lifecycle.
Comment: Interesting perspective on what is a disease and what isn't.

25-040 Mortality before and after the 2003 invasion of Iraq: cluster sample survey.

Roberts L, Lafta R, Garfield R, et al. Lancet. 20 November 2004. Vol.364. No.9448. p.1857-64.
Reviewed by Dr Tony Hanne
Review: Nearly a thousand households in 33 clusters across Iraq were interviewed in September 2004 to compare mortality rates before and after the 2003 coalition invasion. Excluding Falluja, where the death rate was much higher, the estimated additional mortality in the 18 months after the invasion was estimated to be 98 000. Most of the extra deaths were due to violence, principally from the coalition forces and overwhelmingly due to air strikes. The reasons why this estimate is many times

higher than the figures based on media reporting is discussed.
Comment: By any standards this is a remarkable piece of research. The study was conducted rapidly, sensitively and with a sound methodology. What is most impressive is the courage of the interviewers who repeatedly risked their lives to find accurate answers. How many deaths were of combatants is unknown but what is clearly unacceptable is that half of the deaths were of women and children. (See also 25-041 and 25-042)

25-041 The war in Iraq: civilian casualties, political responsibilities.
Horton R. Lancet. 20 November 2004. Vol.364. No.9448. p.1831.
Reviewed by Dr Tony Hanne
Review: See 25-040.

25-042 Mortality before and after the invasion of Iraq in 2003.
Al-Rubeyi BI. Lancet. 20 November 2004. Vol.364. No.9448. p.1834-5.
Reviewed by Dr Tony Hanne
Review: See 25-040.

Genetics

25-043 The hidden genetic program of complex organisms.
Mattick JS. Sci Am. October 2004. Vol.291. No.4. p.60-7.
Reviewed by Dr Ron Vautier
Review: Less than 1.5% of the human genome encodes proteins. The remainder is no longer considered to be 'junk'. Evidently much of it encodes RNA molecules that perform a variety of regulatory functions.
Comment: This new understanding has important implications not only for organisms' development and evolution but also for future pharmaceutical and medical research.

Gynaecology

25-044 Review: vaginal signs and symptoms perform poorly in diagnosing vaginal candidiasis, bacterial vaginosis, and vaginal trichomoniasis.
Doust J. Evidence-Based Medicine. September/October 2004. Vol.9. No.5. p.153.
Reviewed by Dr Bruce Arroll
Review: This was a systematic review of symptoms, signs and laboratory tests in diagnosing vaginal discharges. With the exception of white curdy discharge to rule in vaginal candidosis the other symptoms and signs performed poorly. Lab tests such as pH level, gram bacilli with corkscrew motility and wet mount were all reasonably good at ruling in disease. (Original article reviewed: JAMA 2004; 291: 1368-79)
Comment: The commentator makes the point that it may be better to treat on clinical grounds and only test if treatment fails.

25-045 Maintenance fluconazole therapy for recurrent vulvovaginal candidiasis.
Sobel JD, Wiesenfeld HC, Martens M, et al. N Engl J Med. 26 August 2004. Vol.351. No.9. p.876-83.
Reviewed by Dr Raina Elley
Review: Recurrent vulvovaginal candidiasis is a common condition affecting 5–8% of women during their reproductive years. This multicentred double blind RCT compared weekly oral fluconazole (150mg) for six months with placebo amongst 387 otherwise healthy women with recurrent candidal vulvo-vaginitis. These women had to be asymptomatic at the start of the trial following three doses of fluconazole 150mg administered 72 hours apart. The proportions of women who stayed 'disease-free' at six, nine, and 12 months amongst the fluconazole group were 90.8%, 73.2% and 42.9%, compared with 35.9%, 27.8% and 21.9% respectively in the control group ($p<0.001$). There were few adverse events and no evidence of resistance to fluconazole developing.
Comment: The authors conclude that because of the longer half life of fluconazole (Minimum inhibitory concentration maintained for up to four days), convenient weekly oral administration, demonstrated efficacy, and few side effects, it is a better than other effective prophylactic regimes. These other regimes include daily or weekly intravaginal antimycotic agents or daily ketoconazole, which are more inconvenient and expensive than weekly fluconazole, and oral ketaconazole is associated with hepatotoxicity.

Law and Medicine

25-046 Does my patient have capacity to consent to treatment?
Bird S. Aust Fam Physician. August 2004. Vol.33. No.8. p.638-9.
Reviewed by Dr Rachel Monk
Review: Brief discussion on consent and what is required for an adult patient to have capacity to provide consent.
Comment: Some legislative information which is Australia specific but otherwise useful.

Musculoskeletal System

25-047 Patellofemoral Syndrome: Diagnostic pointers and individualized treatment.
LaBotz M. Physician and Sportsmedicine. July 2004. Vol.32. No.7. p.22-9.
Reviewed by Dr Rob Campbell
Review: This article explores the diagnosis of Patellofemoral syndrome (PFS) and notes the positive signs as well as the absence of signs of other anterior knee problems. Appropriate exercises and other treatment measures are then discussed.
Comment: This is a very helpful article (with a take home patient adviser sheet – attached) and should help you avoid prescribing rest and time as the treatment. Treatment needs to be active.

25-048 Hyperpronation and foot pain: steps toward pain-free feet.

Stovitz SD, Coetzee JC. Physician and Sportsmedicine. August 2004. Vol.32. No.8. p.19-26.
Reviewed by Dr Rob Campbell
Review: This article describes the basic foot function and the importance of hyperpronation. The causes and effects of hyperpronation are discussed and some basic advice on what measures are helpful and which are not.
Comment: Excellent primer for those wishing to understand most foot problems. Stretch the calf and Achilles, strengthen the foot muscles and tibialis posterior and you'll fix most.

25-049 Rehabilitation for postpolio sequelae.

Khan F. Aust Fam Physician. August 2004. Vol.33. No.8. p.621-4.
Reviewed by Dr Rachel Monk
Review: An article on postpolio sequelae (PPS), a disorder occurring at least 15 years after recovery from acute polio. It includes diagnostic criteria and ways to manage common symptoms.
Comment: Interesting article even if you have no known patients with this.

Neurology

25-050 Pain as a sequela of Parkinson disease.

Mott S, Kenrick M, Dixon M, et al. Aust Fam Physician. August 2004. Vol.33. No.8. p.663-4.
Reviewed by Dr Rachel Monk
Review: Pain occurs in 40–46% of patients with Parkinson disease (PD), due to a multitude of causes, yet is is seldom recognised. This study, whilst admitting possible bias, does, however, confirm the finding of pain in PD.
Comment: Asking re pain should be included in the consultation when seeing a patient with PD.

25-051 Three common neuralgias: How to manage trigeminal, occipital, and postherpetic pain.

Ashkenazi A, Levin M. Postgrad Med. September 2004. Vol.116. No.3. p.16-32, 48.
Reviewed by Dr Chris Milne
Review: All these neuralgias are characterised by neuropathic pain, which responds variably to pain modifying drugs such as carbamazepine or gabapentin. Trigeminal neuralgia occasionally requires surgical intervention, and occipital neuralgia may be helped by greater occipital nerve block.
Comment: Useful article about three conditions which GPs see occasionally, but usually not frequently enough to become that familiar with.

25-052 Music and the brain.

Weinberger NM. Sci Am. November 2004. Vol.291. No.5. p.88-95.
Reviewed by Dr Ron Vautier
Review: This article explores how several different regions of the brain respond to, and may be permanently altered by, the perceptual and emotional aspects of music.
Comment: Of little or no practical value, this nevertheless could be expected to provide some interesting reading to the musically-inclined medico.

Nutrition

25-053 Independent association of hip circumference with metabolic profile in different ethnic groups.

Snijder MB, Zimmet PZ, Visser M, et al. Obes Res. September 2004. Vol.12. No.9. p.1370-4.
Reviewed by Dr Anne-Thea McGill
Review: This short report reinforces the accumulating evidence of the independent metabolic benefit of increased fat and probably muscle at the hip and thigh level. The five metabolic syndrome markers of waist circumference, blood pressure, TAG, HDL and glucose were more favourable in those with more hip fat and worse in those with more abdominal fat. It goes further and shows that in males and in various ethnic groups, including some relevant to New Zealand (Micronesian and Indian), that this relationship still holds true.
Comment: This article elegantly shows what primary care health professionals need to know – that waist and hip measurements can tell you more about your patients' health than a crude weight or BMI. The study measured the metabolic syndrome parameters in a reasonable number of participants. Unique, is the inclusion of various ethnic groups whose health risks also are shown to be related to easy-to-do body measurement and common blood tests.

25-054 Patient notes: Following a low-salt diet.

Postgrad Med. August 2004. Vol.116. No.2. p.62.
Reviewed by Dr Chris Milne
Review: A low salt diet is recommended for people with hypertension. This one page handout gives useful tips on reducing foods high in salt (fast foods, salted snack foods, pickled or cured foods, plus tomato or soy sauce). Opt for fresh foods over canned ones. Includes American resource addresses.
Comment: Easy to read information that would be useful for patients. There may be a more 'Kiwified' information sheet available from your hospital dietetic department.

Obstetrics

25-055 STIs in pregnancy: An update for GPs.

Ooi C, Dayan L. Aust Fam Physician. September 2004. Vol.33. No.9. p.723-6.
Reviewed by Dr Rachel Monk
Review: An article reiterating the risk of STIs in pregnancy. Short discussion on a few STIs and special considerations in pregnancy. Raises the issue of screening for STIs in pregnancy (especially chlamydia and HIV). Read in association with the patient education sheet on page 727 (included).
Comment: Useful for all GPs but especially for those involved in maternity care or who have a special interest in sexual health.

Paediatrics

25-056 Effective and ineffective interventions for infant colic.

J Fam Pract. August 2004. Vol.53. No.8. p.604, 606.
Reviewed by Dr Bruce Adlam
Review: Interventions with some evidence of effectiveness for infantile colic include hypoallergenic diets and formula, soy formula, decreased infant stimulation, herbal tea (containing chamomile, vervain, liquorice, fennel, and balm-mint), and dicyclomine (Merbentyl). Reports of severe adverse effects of dicyclomine in infants younger than seven weeks (apnoea, seizure, coma) resulted in a contraindication for use in those aged less than six months. The following interventions are essentially equal to or worse than placebo treatment: simethicone, scopolamine, lactase enzyme (Lactulose), fibre-enriched formula, increased carrying, car-ride simulators, and sucrose. (Level of evidence [LOE] =1a-) (Original article reviewed: Pediatrics 2000; 106:184-190.)
Comment: Useful article that challenges some firmly held beliefs and practices

Pharmacology

25-057 Quinine associated blindness.

Townend BS, Sturm JW, Whyte S. Aust Fam Physician. August 2004. Vol.33. No.8. p.627-8.
Reviewed by Dr Rachel Monk
Review: Quinine is a commonly prescribed medication for leg cramps, although evidence is conflicting regarding its efficacy. Though side effects are rare at appropriate doses, this article uses a case to illustrate the potential severity of those side effects.

Psychiatry and Psychology

25-058 Is methylphenidate useful for treating adolescents with ADHD.

Mott TF, Leach L. J Fam Pract. August 2004. Vol.53. No.8. p.659-61.
Reviewed by Dr Bruce Adlam
Review: Methylphenidate (Ritalin) is effective in the short-term treatment of attention deficit/hyperactivity disorder (ADHD). (Strength of recommendation [SOR]: A, multiple randomized control trials).
Comment: The studies reviewed do not define long-term academic or vocational success, which is a more important outcome than symptom control for adolescents.

25-059 Children and adolescents with developmental disabilities: The GP's role.

Tracy J, Henderson D. Aust Fam Physician. August 2004. Vol.33. No.8. p.591-7.
Reviewed by Dr Rachel Monk
Review: A useful article which explores the GP's central role with the disabled child and their family from diagnosis, through childhood, and into young adulthood.
Comment: Multiple resources suggested, many specifically Australian, but other's might be useful to NZ practice.

25-060 Adults with intellectual disability and the GP.

Lennox N, Eastgate G. Aust Fam Physician. August 2004. Vol.33. No.8. p.601-6.
Reviewed by Dr Rachel Monk
Review: A very brief article about managing adults with intellectual disability. Very useful table on specific problems in certain syndromes including Down syndrome, cerebral palsy and fragile X as well as other less common syndromes.
Comment: Table in particular very useful to have on hand.

25-061 The assessment and treatment of behavioural problems.

Davis R, Mohr C. Aust Fam Physician. August 2004. Vol.33. No.8. p.609-12.
Reviewed by Dr Rachel Monk
Review: Challenging behaviours may be the only way a person with an intellectual disability has of communicating a problem. Underlying medical causes are often overlooked. Remember the importance of an accurate description of the problem and assessment of safety issues.
Comment: Nice reminder of medical problems as an underlying reason for behavioural change.

25-062 When the child with ADHD grows up.

Sim MG, Hulse G, Khong E. Aust Fam Physician. August 2004. Vol.33. No.8. p.615-8.
Reviewed by Dr Rachel Monk
Review: Interesting article based around a case of a 19-year-old man with ADHD. Explores the role of the GP at times when the patient is on and off specific treatments.
Comment: Reminder that ADHD doesn't cease at the end of childhood.

25-063 Vision loss: The patient with developmental disability: Eye Series - 18.

Hodge C, Roberts T. Aust Fam Physician. August 2004. Vol.33. No.8. p.635-6.
Reviewed by Dr Rachel Monk
Review: Useful questions and answers on visual problems in patients with developmental disability (particularly Down syndrome).

25-064 An approach to managing depression: defining and measuring outcomes.

Khullar A, McIntyre RS. Can Fam Physician Med Fam Can. October 2004. Vol.50. p.1374-80.
Reviewed by Dr Mike Lyons
Review: Clear article on major depressive disorder based loosely on a case history to illustrate principles. Starts by cautioning to rule out bipolar disorder with a mood disorder questionnaire. Proceeds to tout the 17 item Hamilton Depression Scale as the best assessment tool. Includes a one page copy of the shortened seven item scale (HAM-D7), useful to copy and issue to patients. Outlines relevant end points, the concept of full remission and a lengthening of maintenance treatment.
Comment: States boldly 'full remission is a valid, objective and achiev-

able therapeutic end point'. However, admits less than 40% experience sustained remission of symptoms (level 1 evidence). Strategies to reach full remission after failure of an initial antidepressant agent or psychotherapeutic approach remain controversial. Likens the new approach to management to our current diabetic management with long-term multimodal treatment and monitoring of end points. Interesting.

Research Design and Methodology

25-065 Intention-to-treat analysis: protecting the integrity of randomization.

Mahaniah K, Rao G. J Fam Pract. August 2004. Vol.53. No.8. p.644.

Reviewed by Dr Bruce Adlam

Review: Another useful one pager on terms we often come across while reading journals. The intention-to-treat principle states that all subjects must be analysed with respect to the group to which they were randomised.

Comment: At first, intention to treat doesn't seem logical. If we are testing an intervention, doesn't it make sense to evaluate its effect among patients who complied with it fully, and then compare them with patients who were not assigned to the intervention or failed to comply? The problem is, patients who fail to comply with an intervention for whatever reason (not attending all training sessions in the example above) may differ in an important way from those who do.

Respiratory System

25-066 A randomized trial of a single dose of oral dexamethasone for mild croup.

Bjornson DL, Klassen TP, Williamson J, et al. N Engl J Med. 23 September 2004. Vol.351. No.13. p.1306-13.

Reviewed by Dr Raina Elley

Review: Croup is a common condition with an annual incidence of 3% for under six-year-olds and a 5% or less hospitalisation rate. Of those admitted, 1% have to be intubated. This double blind RCT of 720 children seen in Canadian emergency departments with mild croup (two or less on the Westley croup scoring system) assessed the effectiveness of oral dexamethasone (dose = 0.6 mg per kilogram) versus placebo. The study found that one dose of oral dexamethasone resulted in fewer return visits to a medical practitioner (7.3 percent versus 15.3 per cent, P<0.001), quicker resolution of symptoms (p=0.003), less sleep lost (p<0.001) and lower parental stress (p<0.001), with no evidence of short-term increased adverse effects.

Comment: Although there is significant evidence that dexamethasone is effective in moderate and severe croup, there was little known about the use in mild croup. While these researchers recommend routine use of dexamethasone in mild croup because of the small benefits, this must be weighed against the uncertainty about long-term effects of even one dose of dexamethasone. Even so, it is useful to know that this treatment is effective and an option for a condition that can be very distressing both for patient and parent.

Rheumatic Diseases

25-067 Steroid injections effective for knee osteoarthritis.

J Fam Pract. August 2004. Vol.53. No.8. p.606.

Reviewed by Dr Bruce Adlam

Review: Intra-articular steroids produced some measure of improvement greater than placebo (NNT 2 to 4). This meta-analysis, however, included relatively few patients, and the magnitude of the benefit was not quantified in this study. (LOE=1a) (Original article reviewed: BMJ 2004; 328: 869-870.)

Sports and Sports Medicine

25-068 Fungal infections and parasitic infestations in sports: Expedient identification and treatment.

Winokur RC, Dexter WW. Physician and Sportsmedicine. October 2004. Vol.32. No.10. p.23-33.

Reviewed by Dr Rob Campbell

Review: The common fungal infections of tinea corporis, capitis, cruris, pedis and versicolor as well as onychomycosis are described. The appropriate treatment and prevention of spread is then described as well as scabies and pediculosis or lice infestations.

Comment: A useful reference paper and especially useful for those looking after teams or school groups.

25-069 Anterior cruciate ligament rupture: is osteoarthritis inevitable?

Feller J. Br J Sports Med. August 2004. Vol.38. No.4. p.383-4.

Reviewed by Dr Chris Milne

Review: In a study of 238 former soccer players with ACL rupture, 58% had undergone ACL reconstruction. However, in about half of the subjects there was x-ray evidence of osteoarthritis. The severity was similar, whether or not the player had undergone ACL reconstruction.

Comment: We have know for several years that ACL injuries are associated with secondary degenerative change. ACL reconstruction prevents episodes of instability, but does not appear to prevent osteoarthritis.

25-070 From catastrophe to complexity: a novel model of integrative central neural regulation of effort and fatigue during exercise in humans.

Noakes TD, St Clair Gibson A, Lambert EV. Br J Sports Med. August 2004. Vol.38. No.4. p.511-4.

Reviewed by Dr Chris Milne

Review: The authors pose an interesting response to the question – why

do muscles not develop rigor during high intensity or prolonged exercise? They propose that the brain acts as a central governor, continually adjusting power output on the basis of metabolic calculations performed at a subconscious level.
Comment: An elegantly argued hypothesis by some of the leading original thinkers in sports medicine. Well worth a read for anyone interested in exercise physiology. (See also 25-071.)

25-071 Logical limitations to the 'catastrophe' models of fatigue during exercise in humans.
Noakes TD, St Clair Gibson A. Br J Sports Med. October 2004. Vol.38. No.5. p.648-9.
Reviewed by Dr Chris Milne
Review: This article suggests that the brain acts as a central governor when we exercise. It stops us pushing ourselves beyond reasonable limits, and ending up in a screaming heap! The authors revisit the early work of AV Hill, and argue against his six major predictions.
Comment: A considered response to a major conundrum within exercise physiology. The authors are renowned for their ability to attack sacred cows with poise and precision. (See also 25-070.)

25-072 Can we manage sport related concussion in children the same as in adults?
McCrory P, Collie A, Anderson V, et al. Br J Sports Med. October 2004. Vol.38. No.5. p.516-9.
Reviewed by Dr Chris Milne
Review: In essence, no we can't. Children are different. The child who is symptomatic following head injury is likely to have sustained a far greater impact compared to an adult with the same symptoms. Children also have a risk of diffuse cerebral swelling after a single head injury.
Comment: For these and many other reasons, it pays to be conservative when managing concussion in children. They MUST be symptom free before returning to play sport.

25-073 Muscle dysfunction versus wear and tear as a cause of exercise related osteoarthritis: an epidemiological update.
Shrier I. Br J Sports Med. October 2004. Vol.38. No.5. p.526-35.
Reviewed by Dr Chris Milne
Review: This review of the clinical literature (18 studies) concluded that muscle dysfunction contributes more to exercise related OA than does wear and tear. This is thought to be because muscle fatigue increases the impact forces crossing a joint. This in turn leads to microtrabecular damage, sclerosis and ultimately joint space narrowing.
Comment: Very comprehensive article by one of the leading thinkers in the sports medicine field. At 10 pages, its only for the dedicated, however!

Surgery

25-074 Open hernia repair better than laparoscopic.
J Fam Pract. August 2004. Vol.53. No.8. p.608-9.
Reviewed by Dr Bruce Adlam
Review: This study of 2224 patients suggests that laparoscopic repair is associated with a small reduction in pain and it gets your patient back to work a day sooner, but it carries a greater risk of serious complications and recurrence. (LOE=1b) (Original article reviewed: N Engl J Med 2004; 350:1819-1827.)

Therapeutics

25-075 Managing bite wounds: Currently recommended for treatment and prophylaxis.
Taplitz RA. Postgrad Med. August 2004. Vol.116. No.2. p.49-59.
Reviewed by Dr Chris Milne
Review: In the USA, the lifetime risk of an animal or human bite is about 50%. Dog, cat and human bites are the most common (no surprises there!). Dog and cat bites frequently involve Pasturella species, which tend to cause infection more rapidly than strep or staph organisms. Augmentin is still the recommended first line agent, or doxycycline if the patient is allergic to penicillin.
Comment: Useful summary of an important clinical problem.

25-076 Virtual-reality therapy.
Hoffman HG. Sci Am. August 2004. Vol.291. No.2. p.58-65.
Reviewed by Dr Ron Vautier
Review: Immersion via special equipment in a 3-dimensional computer-generated virtual world is a very strong distraction, effective in alleviating pain and phobias i.e. more so than ordinary computer games and videos.
Comment: How long will it be before GPs will be expected to have and use such equipment routinely?

25-077 Self-management interventions for chronic illness.
Newman S, Steed L, Mulligan K. Lancet. 23 October 2004. Vol.364. No.9444. p.1523-37.
Reviewed by Dr Tony Hanne
Review: In this seminar, the authors reviewed a large number of randomised control trials of self management interventions (SMIs) in diabetes, asthma and arthritis. The results are by no means clear cut, partly because so many variables were involved. They raised many questions such as who should teach SMIs, is group teaching better than individual, are there better outcomes, are some methods of motivating change better than others, how long does the effect last, and do SMIs save health dollars? (See also 25-078.)
Comment: Despite the lack of confident answers this is a very useful review. As GPs we are very much at the forefront of encouraging patients to take responsibility for their illnesses. At least this seminar can assist us to ask better questions about what we do.

25-078 Self-management in chronic illness.

Gray JA. Lancet. 23 October 2004. Vol.364. No.9444. p.1467-8.

Reviewed by Dr Tony Hanne

Review: See 25-077.

Virus Diseases

25-079 Efficacy of a bivalent L1 virus-like particle vaccine in prevention of infection with human papillomavirus types 16 and 18 in young women: a randomised controlled trial.

Harper DM, Franco EL, Wheeler C, et al. Lancet. 13 November 2004. Vol.364. No.9447. p.1757-65.

Reviewed by Dr Tony Hanne

Review: A new vaccine if it is used worldwide is claimed to be able to prevent about 160 000 deaths per year from cervical cancer. All cervical cancer has been shown to be due to human papillomavirus (HPV). Seventy per cent of these cases are due to types 16 and 18 which are covered in this vaccine. Three doses of this vaccine were shown to be 100% effective in preventing persisting HPV infection, types 16 and 18. The assumption is made that these women would not develop cervical cancer due to these types if vaccinated. The vaccine was well tolerated and safe.

Comment: These results are impressive. If the other types of HPV could be included, presumably cervical screening could one day become a historical curiosity like the use of leeches, always providing that governments paid for the vaccine and anti-immunisation groups did not sabotage the programme. (See also 25-080.)

25-080 Vaccination against human papillomaviruses show great promise.

Lehtinen M, Paavonen J. Lancet. 13 November 2004. Vol.364. No.9447. p.1757-65.

Reviewed by Dr Tony Hanne

Review: See 25-079.

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