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News


Doctors in England are being urged to join a newly launched association that aims to improve the health care of adolescents and listen to the needs of young people. A survey commissioned by the association to coincide with its launch has shown that although health professionals may be concerned about adolescents’ use of drugs, alcohol, and tobacco young people themselves are more worried about body odour, self esteem, and acne. The Association for Young People’s Health (www.youngpeopleshealth.org.uk) has been formed to bring together organisations and professionals who work with young people across health, education, and social services. At the association’s launch last week the minister for public health, Dawn Primarolo, announced $53m funding for contraceptive services, one of the key areas of concern for its members. She said, “We are making progress, but there is still a very high proportion of teenage pregnancies.” She added . . .


Nursing journals are aiding and abetting the drug industry’s attempts to influence nurses’ prescribing, it has been claimed this week. A report in PloS Medicine (2008;5:e5 doi: 10.1371/journal.pmed.0050005) notes that nurses now have greater power to choose products and services and to influence choices made by doctors and other clinical colleagues. As a result, say the New Zealand authors, Annemarie Jutel of Otago Polytechnic and David Menkes of the University of Auckland, nurses are now a “desirable target” for the industry. However, they say, although medical journals have often criticised drug companies for exploiting patients and doctors through techniques such as direct to consumer advertising, ghost writing, gifts, and free meals, the nursing literature “has yet to pay much attention” to the issue. To study the industry’s relationship with the nursing press the authors searched nursing journals in two leading clinical news databases, MedLine and Cinahl, in May 2007. . . .


Routine screening in primary care for alcohol misuse, reduced opening hours of licensed premises, higher taxes on alcohol, a lowering of the drink driving limit, random roadside breath testing, and tobacco style health warnings on bottles are all urged in a new report from the BMA’s board of science. The board’s evidence based recommendations for change aim to tackle the burden of alcohol misuse in the United Kingdom.
Women’s sexual behaviour is influenced by the cost of having an abortion, new research in the United States shows. It found that a 10% increase in the cost of an abortion was associated with a 6.5% drop in the pregnancy rate among women of childbearing age (Social Science Journal doi: 10.1016/j.soscij.2007.12.009). It also found that the pregnancy rate among women of childbearing age, and particularly among teenagers, was lower in states with laws requiring the notification or permission of a parent before a minor can obtain an abortion. However, it found no such association with other restrictive practices, such as mandatory counselling and restrictions on funding for abortion services from the Medicaid health insurance programme for poor people. The authors wrote that their results “support the hypothesis that women’s sexual behaviour is influenced by the direct cost of obtaining an abortion and to a lesser extent the indirect costs . . .


A report from the Royal College of Physicians criticises the audiological and audiovestibular care provided by the NHS in the United Kingdom, and it calls for more integrated services and the rapid training of more specialists. Waiting times for audiology services can be long, despite recent improvements, and patients are often treated by specialists in other disciplines, particularly by ear, nose, and throat (ENT) specialists, the report has found. The NHS does not track waiting times for many audiological treatments, but the most recent data, from December 2006, showed 166 740 patients awaiting audiology assessments, with roughly two thirds waiting more than 13 weeks. “Research suggests that patients with quite routine vestibular disorders often aren’t getting a proper diagnosis until their third or fourth doctor’s visit,” said Linda Luxon, professor of audiological medicine at the University of London’s Institute of Child Health, and the principal author of the report.


The government is to set aside £42m for health authorities in England that choose to add fluoride to drinking water, the health secretary, Alan Johnson, told parliament last week. It is planning to encourage health authorities to consult locally on the matter. Health authorities have been able to decide whether water supplies have fluoride added since the passage of the Water (Flouridation) Act 1985. They have been actively encouraged to do so since MPs amended the act in a free vote in 2003. The law demands, however, that authorities first hold consultations with all interested local parties. Mr Johnson said last week that the government believed that adding fluoride to drinking water was “an effective and relatively easy way to help address health inequalities—giving children from poorer backgrounds a dental health boost that can last a lifetime.” But some of the scientists who led the research that . . .


Health secretary Alan Johnson defended his department’s decision to try to restrict the number of medical graduates entering the United Kingdom from outside the European Economic Area (EEA) during his evidence on Monday afternoon to the parliamentary health select committee. Kevin Barron, chairman of the committee, which is investigating the government’s Modernising Medical Careers (MMC) policy, asked whether the minister felt a moral obligation towards those overseas doctors who had helped to support the NHS for so long. “No one could suggest in any way that this is failing to meet some moral obligation. This is the right way to go,” Mr Johnson said. “The contribution international medical graduates have made has been enormous. “You are quite right we would not have been able to run the health service without their contribution. But we have drained the world of medical graduates. I don’t think it was the right policy for . . .


GPs’ leaders last week appeared to have given in to government pressure to extend the opening hours of general practices. In a letter to GPs ahead of a poll this month to gauge attitudes to the changes to their contract the BMA’s General Practitioners Committee advises members that accepting the latest offer will be better than having a tougher deal imposed on them in April. Under the deal GPs’ surgeries would be open for an additional 30 minutes per week per 1000 registered patients, in blocks of 1.5 hours after 6.30 pm or for 1
The number of doctors in the United Kingdom grew more slowly than in other European countries in the first five years of this century, but the ratio of doctors to the population still remains lower than in many of them. The ratio rose from two doctors per 1000 people in 2000-1 to 2.4 in 2005-6, but it was still only two thirds the ratio in France, Germany, or Italy. The figures, published by the Office of Health Economics, also show that the total number of inpatients and patients treated as day cases in NHS hospitals in the UK grew by more than 15% in the same five years. The number was 17.1 million in 2005-6, 15% higher than in 2000-1. These figures were measured as finished consultant episodes or discharges (periods of care spent under one consultant in one NHS trust) in England and as hospital discharges and deaths in . . .


Two groups of GPs have written to two primary care trusts (PCTs) in London expressing concern about the potential effect on the quality of care after a second contract to run a general practice has been awarded to a private company rather than to local GPs. Camden Primary Care Trust announced in late January that it had awarded the tender to run three GP surgeries—King’s Cross Road Practice, Camden Road Practice, and Brunswick Medical Centre—to UnitedHealth Primary Care (BMJ 2008;336:295, 9 Feb doi: 10.1136/bmj.39481.889155.C2). Four local GPs who bid for Brunswick Medical Centre, which they had been managing successfully for the previous six months, have written to Camden PCT expressing their concern that “patient care will suffer.” They believe that the decision was based “purely on cost, as opposed to quality.” Previously, another London PCT, Tower Hamlets, awarded a tender to run St Paul’s Way Medical Centre to . . .


The National Heart, Lung, and Blood Institute, part of the US National Institutes of Health, has stopped the intensive glucose lowering arm of a major trial in type 2 diabetes after more patients died than in the standard treatment group. The action to control cardiovascular risk in diabetes (ACCORD) study involved 10 251 adults aged 40-82 years with type 2 diabetes who had two or more additional risk factors for heart disease or who already had a diagnosis of heart disease. They were randomised to intensive glucose lowering treatment, in which the target haemoglobin A1c (HbA1c) concentration was <6%, or to less intensive, standard treatment to reach the average HbA1c (7% to 7.9%) currently achieved in the United States by such treatment. The Data and Safety Monitoring Board, the independent group that was monitoring the trial, recommended that the trial be stopped when it found that more deaths occurred . . .

The government must do more to support war veterans and the families of service personnel, says a report published by the House of Commons Defence Select Committee. The report, published on Monday, has found that although the clinical care of servicemen and servicewomen injured in manoeuvres is “world class,” more needs to be done to help veterans and the families of personnel in the armed services, particularly in the provision of mental health services. The chairman of the committee, James Arbuthnot (Conservative MP for Hampshire North East) said that the Ministry of Defence (MoD) needed to do more to look after families and veterans. He said that although the government had made steps to extend priority, fast track, access to health care for veterans “too much is being left to good intentions and good luck.” “Unless the NHS can identify those who are entitled, priority access can be an empty . . .


Humanitarian officials fear that recent fighting in Chad—the worst in decades of sporadic civil conflict—could have a catastrophic effect on millions of people displaced by the violence in Darfur in neighbouring Sudan. They caution that if the crisis is not immediately resolved it could soon spread across the region. UN secretary general Ban Ki-Moon warned that there could be “devastating consequences not only for the people of Chad and Darfurian refugees seeking shelter there but also for Darfur itself.” He insisted that the deployment of the hybrid United Nations and African Union peacekeeping force, known as UNAMID, must be speeded up, and he urged member states to properly equip the troops. “UNAMID still lacks required aviation and ground transportation, chiefly helicopters,” said the secretary general. “Those countries that called for intervention in Darfur are under special obligation to deliver on their promises.”


Ten million children under 5 years old die each year across the world, warns Save the Children in a new campaign aimed at getting countries back on target to achieve the millennium development goal to reduce mortality in under 5s by two thirds by 2015. The charity has compiled a “wealth and survival index” that compares child mortality in each country with its national income per person. It claims that the index shows “who is making the most of what they have and who is squandering their resources.” Its director of policy, David Mepham, said, “A child’s chance of making it to its fifth birthday depends on the country or community it is born into. This sounds like a lottery, something beyond human control, but this should not be the case.” He added, “While poverty and inequality are consistent underlying causes of child deaths, all countries—even the poorest—can cut child . . .


India’s health ministry, in the wake of a racket involving illegal kidney transplantations, has announced plans to promote donations from cadavers. It will allow more hospitals to harvest organs from brain stem dead patients and offer incentives to relatives of dead donors. Police have arrested a doctor, Amit Kumar, and his associates, for allegedly performing hundreds of clandestine kidney transplantations in Gurgaon, an industrial town near New Delhi. Police claim that Dr Kumar used a network of touts to lure poor people into giving up their kidneys for payments of about 60 000 rupees and that the organs were transplanted into patients from India, Europe, and the United States. India outlawed trade in human organs in 1994, but transplantation surgeons have said that organ sales have persisted because of a shortage of cadaver donors and collusion among donors, doctors, and patients waiting for a transplant.


The government has announced new temporary immigration regulations that will bar doctors from beyond the European Union from gaining postgraduate medical training places in the United Kingdom. The new Home Office rules will prohibit foreign doctors from taking training posts in the UK by applying through the highly skilled migrant programme, the traditional route to take up a post offered without a work permit. The regulations are temporary until the Department of Health decides whether or not to implement its own guidance which gives priority to doctors trained in the UK. At present, this guidance is subject to consideration by the House of Lords, a three month consultation exercise, and an equality impact assessment. The Department of Health said last week that the Home Office’s changes would reduce the potential pool of migrants applying to UK postgraduate medical training from 5000 to 3000 in 2009. Doctors who currently have highly . . .


GPs are being asked by the BMA to comment on government health policy and on new private providers in general practice as part of an ongoing argument over extended hours. This week the BMA launched a poll of its GP members on the two options put forward by the
government to extend opening hours in general practice. But it has also included several other political questions in the poll, which is thought likely to annoy the government and which indicates that relations are still frosty between the two sides. Although the BMA is unhappy about either option, it has urged its members to choose the government’s first option as the lesser of two evils. Under this option GPs’ surgeries would be open for an extra 30 minutes a week per 1000 registered patients, after 6 30 pm or before 8 am or on a Saturday morning.


The Australian prime minister, Kevin Rudd, has vowed to establish a bipartisan “war cabinet” to help tackle the stark disadvantages faced by indigenous Australians. The promise, which has been welcomed by many in the field of indigenous peoples’ health, followed Rudd’s historic apology last week to the “stolen generations”—the tens of thousands of Aboriginal, Torres Strait Islander and mixed race children taken from their families between 1910 and 1970. “For the pain, suffering, and hurt of these stolen generations, their descendants and for their families left behind, we say sorry,” Mr Rudd said in parliament. “To the mothers and the fathers, the brothers and the sisters, for the breaking up of families and communities, we say sorry. “And for the indignity and degradation thus inflicted on a proud people and a proud culture, we say sorry.” After delivering his apology, Mr Rudd called on the opposition leader Brendan Nelson to . . .


Seven doctors and pharmacists went on trial in France last week over the death of at least 110 people who became infected with Creutzfeldt-Jakob disease after being given tainted human growth hormone when they were children. The United States, Britain, and other countries halted the distribution of growth hormone in 1985, after it was discovered that three people had died after being given the product. Growth hormone at that time was extracted from pituitary glands removed from corpses. The cause of some subsequent deaths was Creutzfeldt-Jakob disease. Doctors in France, however, continued to use the hormone for several years, treating thousands of children, before turning to a synthetic substitute in 1988 (BMJ 1997;314:165). After the first death in France was recorded in 1991 the family took to court the company responsible for collecting the pituitary glands, France-Hypophyse, along with the Pasteur Institute, which prepared the treatment, and the Pharmacie . . .


The failure of the United States to contain medical costs, which now exceed $2.1 trillion a year or more than $7000 for every man, woman, and child in the country, results primarily from the unique and pervasive commercialisation of the sector, an article in this week’s New England Journal of Medicine says (2008;358;549-51). In the perspective article Robert Kuttner, coeditor of the magazine The American Prospect and a senior fellow at Demos, a public policy research and advocacy organisation based in New York, contends that what raises costs and distorts resource allocation are “the dominance of for-profit insurance and pharmaceutical companies, a new wave of investor-owned specialty hospitals, and profit-maximising behaviour even by nonprofit players.” He continues: “Profits, billing, marketing, and the gratuitous costs of private bureaucracies siphon off $400 billion to $500 billion of the $2.1 trillion spent, but the more serious and less appreciated syndrome . . .


Two sets of parents in Belgium who refused to have their children vaccinated against polio, which is compulsory under Belgian law, were convicted earlier this month. Each parent was fined (£4100; $8000) and sentenced to five months in prison. In an interview with the BMJ the presiding judge, Bart Meganck of the Court of First Instance in the Flemish city of Dendermonde, said that the parents failed to appear for the 4 February court date. He therefore convicted them on the basis of police reports. He suspended the prison sentences pending whether or not the children receive polio vaccinations. Asked what would happen if the parents still refuse, Judge Meganck said: “I don’t think that will happen.” He explained that if they fail to obey the court then that would be a “new crime” and they would receive a new summons to appear in court. Since the late 1960s . . .


The US decline in coronary artery disease may have ended in the mid 1990s and the disease may even be increasing, reports an unusually comprehensive autopsy study from the Mayo Clinic and the University of British Columbia. “Our finding that temporal declines in the grade of coronary artery disease at autopsy have ended, together with suggestive evidence that declines have recently reversed, provides some of the first data to support increasing concerns that declines in heart disease mortality may not continue,” the authors write. A possible reason may be the recent epidemics of obe-
sity and diabetes, which began at about the time when coronary artery disease blockages in their study were no longer declining. The study, published in the Archives of Internal Medicine, reviewed the incidence of coronary artery disease among 515 residents aged 16 to 64 of Olmsted County, Minnesota, who died from accidents, suicide, homicide, or other . . .


Baxter Healthcare Corporation, which provides half the supply of heparin in the United States, recalled multidose vials of heparin sodium last month after four deaths and 350 reports of adverse events, 40% of which were serious. More than one million multidose vials are sold each month in the US, and half of them are produced by Baxter. The US Food and Drug Administration said the source of the heparin, which is made from pig intestines, was imported from China. The FDA said it had not inspected the Chinese plant that produced it. The initial recall of heparin last month involved nine lots of multidose vials. Since then, Baxter has received reports of adverse reactions with other lots, the company said. Baxter and the FDA are investigating the problem. A report in the New York Times said that a manufacturing facility in China, Changzhou SPL, which produced the ingredient for heparin, . . .


A seven year investigation into the work of Germany’s largest organisation that funds research, between 1920 and 1970 has confirmed that German scientists used the Nazis’ totalitarian regime to conduct lethal experiments. The German research foundation (Deutsche Forschungsgemeinschaft) remains the country’s largest funder of research, with an annual budget of about (£970m; $1.9bn). The independent investigation found that the organisation and most of the scientists it funded had succumbed to serving the Nazi regime “almost completely and without scruple” after its rise to power in 1933. This started with the expulsion of Jewish and other scientists not in political favour from the foundation and from German universities. And it escalated to the experiments on Jewish prisoners conducted by Josef Mengele at Auschwitz, which were supported financially by the foundation. Reporting the findings of the seven year investigation at a conference last week in Berlin, Matthias Kleiner, president of the . . .


Men and women took to the streets of Italy last week to protest about police behaviour towards a woman who had had a late abortion for fetal abnormality. A police patrol of seven rushed into the Naples University Hospital, Federico II, after they received an anonymous phone call saying that an illegal abortion had taken place in the hospital’s gynaecology department. Press reports say that the police interrogated the 39 year old woman as she got back to her room immediately after the procedure and seized the aborted fetus, even though the head of the department rapidly proved that the procedure was legal, as an amniocentesis at week 21 had shown that the fetus was affected by Klinefelter’s syndrome. The police raid was seen by many people as intimidation and caused demonstrations all over Italy. Livia Turco, health minister in Romano Prodi’s outgoing centre left government, took part in a . . .


The number of Ugandans with AIDS who are being treated with antiretroviral drugs is now 110 000, but health authorities say that more than twice that number should be receiving them. “We have about one million people with AIDS in the country,” said Emmanuel Otala, Uganda’s minister for primary health care, last week. “A total of 250 000 deserve to be put on the ARVs [antiretrovirals] because their CD4 count has reduced to below 200. Of these, so far there are only 110 000 on the drugs, and we have a deficit of 140 000 who would otherwise be on the ARVs. The resources are limited, because we depend on donors.” Dr Otala said that about 94 000 patients with AIDS were taking antiretrovirals at the beginning of 2007, with slightly more than 1000 new patients being put on the drugs every month. The country was the second in Africa . . .


Slovenia has chosen combating cancer as its top public health priority while it holds the six month presidency of the European Union. The government made its intentions clear when it organised a two day conference on the subject in Brdo pri Kranju last week and presented the findings of a new wide ranging report, Responding to the Challenge of Cancer in Europe. Zofija Mazej Kukovic, the Slovenian health minister, explained that her government, which holds the rotating EU presidency until the end of June, would like to see national authorities increasing concerted action against cancer. This should focus on initiatives to reduce cancer incidence and mortality, improve cancer outcomes, narrow health gaps in the prevention and control of cancer between different countries, and increase benefits for patients. The report, which contains a series of contributions from leading European experts on different aspects of cancer control, was funded by the EU’s . . .

Health and nutrition loom large in Unicef’s 2008 emergencies appeal, launched last week. The agency is calling for donors to provide $856m to help the children and women who are victims of 39 current emergencies around the world, the vast majority of which are in sub-Saharan Africa. “Children and women continue to bear the brunt of conflict and displacement,” said Hilde Johnson, Unicef’s deputy executive director, at a press conference in Geneva. In a foreword to the organisation’s action report for this year, Ann Veneman, Unicef’s executive director, wrote: “We count on the continued support and generosity of our donors to help ensure the survival, protection and well-being of women and children in these emergency situations.” In many of the world’s trouble spots, including Sudan, Somalia, and the Democratic Republic of Congo, Unicef is seeking large amounts of new funds to help the millions of people who continue . . .


Health care in the Gaza Strip remains dire, top UN humanitarian officials have warned. Essential drugs, medical supplies and parts, and fuel to power hospital generators are in acute shortage, and travel for patients who are seeking urgent treatment outside the area is restricted. The same officials have emphasised that the situation could deteriorate further unless Israel eases the restrictions that have curtailed the flow of humanitarian and commercial supplies to meet the needs of the 1.5 million population in Gaza. The World Health Organization in its latest biannual plan for humanitarian action cautions that chronic situations, such as that in the Palestinian territories occupied by Israel “will continue to deteriorate and will thus require significant resources in 2008-9.” “I have been shocked by the grim and miserable things that I have seen and heard today, which are the result of current restrictions and the limitations on the number of . . .

ANALYSIS


Monitoring entails periodic measurement to guide management1 and is widely practised in clinical medicine to inform decisions throughout the course of a disease and to provide prognostic information to patients. It is helpful to divide monitoring into phases: pretreatment, initial response, maintenance, re-establish control, and post-treatment.1 Initial response monitoring uses repeat measurement soon after a new treatment is started to check that the response is within a range that maximises the benefits while minimising the harms. Table 1 summarises different types of initial response monitoring. We have limited our discussion to the use of surrogate outcomes for monitoring initial response to treatment. Surrogate outcomes are commonly used to monitor initial response in patients with chronic conditions. This type of initial response monitoring is common in clinical practice and can result in inappropriate decisions. We looked at two scenarios to develop a rational framework for deciding whether this form of initial . . .

RESEARCH


All cause mortality rates declined over the 25 year study period in all groups stratified by sex, age, and income, except for 25-44 year olds of both sexes on low incomes among whom there was little change. In all age groups pooled, relative inequalities increased from 1981-4 to 1996-9 (RIIs increased from 1.85 (95% confidence interval 1.67 to 2.04) to 2.54 (2.29 to 2.82) for males and from 1.54 (1.35 to 1.76) to 2.12 (1.88 to 2.39) for females), then stabilised in 2001-4 (RIIs of 2.60 (2.34 to 2.89) and 2.18 (1.93 to 2.45), respectively). Absolute inequalities were stable over time, with a possible fall from 1996-9 to 2001-4. Cardiovascular disease was the major contributor to the observed disparities between income and mortality but decreased in importance from 45% in 1981-4 to 33% in 2001-4 for males and from 50% to 29% for females. The corresponding contribution of cancer increased from 16% to 22% for males and from 12% to 25% for females. During and after restructuring of the economy disparities in mortality between income groups in New Zealand increased in relative terms (but not in absolute terms), but it is difficult to confidently draw a causal link with structural reforms. The contribution of different causes of death to this inequality changed over time, indicating a need to re-
prioritise health policy accordingly.


The primary search focused on randomised controlled trials and the secondary search on cohort studies with a concurrent control group. Interventions aimed to modify techniques for lifting and handling heavy objects or patients and including measurements for back pain, consequent disability, or sick leave as the main outcome were considered for the review. Two authors independently assessed eligibility of the studies and methodological quality of those included. For data synthesis, we summarised the results of studies comparing similar interventions. We used odds ratios and effect sizes to combine the results in a meta-analysis. Finally, we compared the conclusions of the primary and secondary analyses. Six randomised trials and five cohort studies met the inclusion criteria. Two randomised trials and all cohort studies were labelled as high quality. Eight studies looked at lifting and moving patients, and three studies were conducted among baggage handlers or postal workers. Those in control groups received no intervention or minimal training, physical exercise, or use of back belts. None of the comparisons in randomised trials (17 720 participants) yielded significant differences. In the secondary analysis, none of the cohort studies (772 participants) had significant results, which supports the results of the randomised trials. There is no evidence to support use of advice or training in working techniques with or without lifting equipment for preventing back pain or consequent disability. The findings challenge current widespread practice of advising workers on correct lifting technique.


Functional status at six months after stroke assessed with modified Rankin scale or “two simple questions.” Mortality during follow-up. Survival analysis with Kaplan-Meier curves, log rank test, and Cox’s regression model. In a combined analysis of all three cohorts, among patients who survived to assessment six months after the index stroke, the subsequent median length of survival among those independent in daily living and those dependent was 9.7 years (95% confidence interval 8.9 to 10.6) and 6.0 years (5.7 to 6.4), respectively. In a combined analysis of the Oxfordshire and Lothian cohorts, subsequent median survival fell progressively from 12.9 years (10.0 to 15.9) for patients with a Rankin score of 0-1 at six months after the stroke to 2.5 years (1.4 to 3.5) for patients with a Rankin score of 5. All previously stated differences in median survival were significant (log rank test P<0.001). The influence of functional outcome on survival remained significant (P<0.05) in each cohort after adjustment for relevant covariates (such as age, presence of atrial fibrillation, visible infarct on computed tomography, subtype of stroke) in a Cox’s regression model.


Relative risk of recurrence of isolated clefts from parent to child and between full siblings, for anatomic subgroups of clefts. Among first degree relatives, the relative risk of recurrence of cleft was 32 (95% confidence interval 24.6 to 40.3) for any cleft lip and 56 (37.2 to 84.8) for cleft palate only (P difference=0.02). The risk of clefts among children of affected mothers and affected fathers was similar. Risks of recurrence were also similar for parent-offspring and sibling-sibling pairs. The “crossover” risk between any cleft lip and cleft palate only was 3.0 (1.3 to 6.7). The severity of the primary case was unrelated to the risk of recurrence. The stronger family recurrence of cleft palate only suggests a larger genetic component for cleft palate only than for any cleft lip. The weaker risk of crossover between the two types of cleft indicates relatively distinct causes. The similarity of mother-offspring, father-offspring, and sibling-sibling risks is consistent with genetic risk that works chiefly through fetal genes. Anatomical severity does not affect the recurrence risk in first degree relatives, which argues against a multifactorial threshold model of causation.


Self reported post-traumatic stress disorder as measured by the posttraumatic stress disorder checklist—civilian version using Diagnostic and Statistical Manual of Mental Disorders, fourth edition criteria. More than 40% of the cohort were deployed between 2001 and 2006; between baseline and follow-up, 24% deployed for the first time in support of the wars in Iraq and Afghanistan. New incidence rates of 10-13 cases per 1000 person years occurred in the millennium cohort. New onset self reported post-traumatic stress disorder symptoms or diagnosis were identified in 7.6-8.7% of deployers who reported combat exposures, 1.4-2.1% of deployers who
did not report combat exposures, and 2.3-3.0% of non-deployers. Among those with self reported symptoms of post-traumatic stress disorder at baseline, deployment did not affect persistence of symptoms. After adjustment for baseline characteristics, these prospective data indicate a threefold increase in new onset self reported post-traumatic stress disorder symptoms or diagnosis among deployed military personnel who reported combat exposures. The findings define the importance of post-traumatic stress disorder in this population and emphasise that specific combat exposures, rather than deployment itself, significantly affect the onset of symptoms of post-traumatic stress disorder after deployment.

**CLINICAL REVIEW**


Haemorrhoids or “piles” are enlarged vascular cushions within the anal canal that have been described for many centuries and continue to form a large part of a colorectal surgeon’s workload. The exact incidence of this common condition is difficult to estimate as many people are reluctant to seek medical advice for various personal, cultural, and socioeconomic reasons, but epidemiological studies report a prevalence varying from 4.4% in adults in the United States to over 30% in general practice in London.1 2 The treatment of haemorrhoids is still evolving, and this article provides an update on the role of established and innovative treatments.


A study by the World Health Organization ranked depression the fourth global burden of disease and found it to be the largest non-fatal burden of disease, with nearly 12% of total years lived with disability.1 According to the cross sectional WHO world health survey, carried out in all regions of the world (60 countries), the one year prevalence of a depressive episode (international classification of diseases, 10th revision) was 3.2% (95% confidence interval 3.0% to 3.5%). In patients with several medical conditions the prevalence of depression exceeds that of the general population,2 with 5-10% of patients affected in primary care and 10-14% of patients under general hospital care.3 The diagnosis and treatment of depression by general practitioners is not, however, always optimal.4 5 We review the presentation and assessment of depression and discuss the options for its effective treatment and management.