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NEWS


Australia’s drug industry has said that in the last six months of 2007 alone it organised more than 14 633 “educational events” for the benefit of medical professionals. Detailed monthly reports by 43 companies show that they spent more than $A31m and attracted 385 221 people to the events. Although many meetings were held in hospitals and attracted attendances of only about two dozen, others were more elaborate affairs. Amgen Australia, for example, spent $328 206 on food, alcohol, travel, and accommodation at a Sydney hotel for a two day clinical haematology symposium attended by 142 haematologists and trainees. Amgen sells a range of haematology drugs. In July 2006 the Australian Competition and Consumer Commission, a government regulatory agency, reauthorised the self regulatory code of conduct developed by Medicines Australia, the major drug industry group. However, the commission required member companies to submit monthly reports detailing each . . .


NHS trusts and organisations that provide NHS funded health care will be allowed to advertise their services as part of a government drive to improve patient choice, the health minister Ben Bradshaw has said. The announcement came at the launch of a code of practice for services funded by the NHS. From this April GPs will be able to refer patients to NHS hospitals and some independent sector treatment centres anywhere in England for routine elective treatment. The government hopes that by allowing providers to promote their services, patients will be empowered “to have a real say in their treatment” and that publication of information on the quality of services will “provide an incentive for improvement.” Healthcare providers will be able to compete for business by advertising results such as their waiting times, surgical outcomes, and rates of methicillin resistant Staphylococcus aureus. Testimonials and endorsements from celebrities, medical experts, . . .


Almost half (46%) of the United Kingdom’s drug companies expect to cut back on clinical trials in the coming year because of continued uncertainty about future arrangements for pricing drugs. In a survey of more than 100 companies earlier this month on behalf of the Association of the British Pharmaceutical Industry and the Confederation of British Industry three quarters said they had little confidence in the current
UK market environment, and 83% expected things to get worse in the next year. The survey also showed that 30% of drug companies expect to cut staff in the next year, and more than a third expect to reduce research and development and investment in buildings and equipment. Two in five anticipated cutting back on manufacturing in the UK. Despite this, almost two thirds thought their own business would grow in the coming year, and 43% thought their performance would improve. But nearly . . .


Doctors must be prepared to set aside their religious and other personal beliefs if these compromise the care of patients, according to the latest ethical guidance from the UK General Medical Council. This could include removing a Muslim doctor’s face veil if it impedes proper communication between patient and doctor, the guidance implies. “Some patients, for example, may find that a face veil worn by their doctor presents an obstacle to effective communication and the development of trust.” it says. “You must be prepared to respond to a patient’s individual needs and take steps to anticipate and overcome any perceived barrier to communication. In some situations this may require you to set aside your personal and cultural preferences in order to provide effective patient care.” Doctors who oppose abortion on grounds of conscience are told that although they may refuse to carry out the procedure they must tell the patient . . .


A comprehensive, evidence based guide to the physical signs of sexual abuse of children was published this week by the Royal College of Paediatrics and Child Health. He long awaited publication, which is based on five years’ work, will help UK child protection professionals diagnose sexual abuse of suspected victims and gives advice on how they can best present their evidence in criminal and family court cases. It will also ensure that professionals use an agreed terminology to describe signs, so that everyone involved in a case knows what is meant. Rosalyn Proops, child protection officer for the college, said, “It provides clinicians—paediatricians in particular—with a common language to describe the physical signs, and that is the key to writing better reports and safer practice for children, families, and paediatricians.” The college’s project has uncovered a scarcity of high quality research on the subject, and the guide highlights the absence . . .


A US federal judge in Illinois has rejected a bid by the drug company Pfizer to force two leading medical journals to hand over confidential documents relating to peer review of studies on its cyclo-oxygenase-2 inhibitors valdecoxib (Bextra) and celecoxib (Celebrex). The company sought the documents from a number of journals, including the BMJ, to help it defend 3000 product liability lawsuits over alleged side effects of the two drugs. But the journals have strongly contested the move as a threat to the process of peer review. In the first case to reach a court ruling so far, a judge has rejected the motion for access to peer review documents held by JAMA and the Archives of Internal Medicine. Pfizer had initially asked for peer reviewers’ identities but later modified its request, saying in a statement, “Pfizer seeks only to obtain those peer reviewed comments that have been . . .


The doctor at the centre of a major public health scare over vaccinations gave evidence this week before a General Medical Council panel, where he and two colleagues stand accused of research misconduct. Andrew Wakefield, whose research paper and comments in 1998 linking the combined measles, mumps, and rubella (MMR) vaccine to autism led to a sharp fall in uptake of the vaccine, told the hearing that he was motivated by concern for autistic children. He read out a letter that he had sent in 1997 to John Walker-Smith, now also accused of misconduct by the GMC, in which he wrote: “If these diseases are found to be linked to the MMR vaccine, these children are the few unfortunate who have been sacrificed to protect the majority.” In that letter he defended his involvement with solicitors acting on behalf of parents seeking compensation from vaccine manufacturers. Six years after the . . .
A former senior lecturer at the University of London’s Institute of Psychiatry has been struck off after a General Medical Council panel found that he repeatedly lied about ethics committee approval for his studies. The GMC also found that he misrepresented his academic qualifications, misused drug companies’ proprietary data, recruited mentally ill patients without notifying their GPs, and conducted diagnostic tests without patients’ consent or ethics committee approval.

Tonmoy Sharma, 42, described by the GMC panel as a "research psychiatrist of international repute,” falsely claimed on five occasions to have obtained ethics committee approval for proposed studies involving antipsychotics and other drugs. He made these claims to local research ethics committees, to the Alzheimer’s Society, and to the drug company then called Sanofi Synthélabo. Dr Sharma misled Sanofi into believing that a study comparing schizophrenia drugs was being conducted under the auspices of the Institute of Psychiatry, when in fact . . .


Healthcare inspectors are launching an official investigation this week into numbers of deaths at Mid Staffordshire NHS Foundation Trust, which they suspect may be excessively high, particularly among patients admitted as emergencies. The Healthcare Commission said that it was alerted last September to possible problems in the trust’s systems for monitoring mortality. Since then it had visited the trust twice and found that its death rates were higher than those in similar trusts in England. However, the commission refused to say which time period was being investigated or to give the number of deaths until after the investigation. Nigel Ellis, who heads the commission’s investigation unit, said, “An apparently high rate of mortality does not necessarily mean there are problems with safety. It may be that there are other factors here, such as the way that information about patients is recorded by the trust. Either way, it does . . .


Doctors and midwives are being asked to screen all pregnant women for risk factors for gestational diabetes at their first booking appointment and to offer them a test for the condition if their risk is raised. The recommendation is included in the revised guidance from the National Institute for Health and Clinical Excellence on the routine care that should be offered to all pregnant women in England, which was first published in 2003. Risk factors for gestational diabetes include a body mass index greater than 30; previous macrosomic baby above 4.5 kg; previous gestational diabetes; family history of diabetes; and family origin with high prevalence of diabetes, such as South Asian, black Caribbean, and Middle Eastern. The guidance also says that the combined test to screen for Down’s syndrome (nuchal translucency, a human chorionic gonadotrophin, and pregnancy associated plasma protein A) should be offered earlier whenever possible—at between 11 weeks . . .


Everyone in England aged between 40 and 74 is to be offered a health check every five years to screen for the risk of heart disease, diabetes, kidney disease, and stroke, the Department of Health announced this week. The health checks are the latest in a series of reforms designed to fulfill the prime minister’s promise of a more personalised NHS. Alan Johnson, the secretary of state for health, said that detailed modelling by the department had shown that universal vascular screening would be clinically and cost effective. Vascular disease affects four million people in England and kills 170 000 people every year, he said. “The case for a national programme of vascular checks is compelling. We could prevent 9500 heart attacks and strokes every year and save 2000 lives. It would also reduce the health inequalities that blight the lives of the country’s most deprived families,” said Mr Johnson.


After a year of controversy over the relative safety of drug eluting stents and bare metal stents, the US Food and Drug Administration has issued guidance to the industry on the development and testing of stents. It recommends that all clinical trials should have a follow-up period of 12 months, instead of the current nine months, and that a data monitoring committee should continuously review all studies of drug eluting stents. The agency, which issued the guidance last week, will accept public comments on the recommendations for 120 days before it issues its final guidance. Daniel Schultz, director of the agency’s Center for Devices and Radiological Health, said that the draft guidance “is part of FDA’s ongoing effort to provide regulated industry with recommendations on measures that can minimise the risks while preserving for patients the benefits of drug eluting stents.” The guidance comes in response to a fractious debate . . .


A radical prostatectomy using a robot was transmitted live to a group of surgeons and mechanical engineers...
last week to stimulate collaboration between the professions and encourage developments in robotic surgery. The operation was performed at Guy’s Hospital, London, by Prokar Dasgupta, reader and consultant urological surgeon at the hospital and King’s College London, School of Medicine, and transmitted to an audience at the Institution of Mechanical Engineers in London. “For the last couple of years we have been collaborating with our mechanical engineers at King’s College London to refine and develop new robotic tools,” he said. “Working with highly qualified scientists has the potential to take these tools from bench to bedside, which we believe is the way forward.” Consequently he and Jian Dai from King’s College London organised a two day conference to discuss the latest developments in robotic surgery: hear about patients’ feedback; debate future directions with . . .


The UK government last week published its formal response to Nigel Crisp’s report on global health partnerships, which recommended improving coordination between medical professionals in the United Kingdom and poor countries and making access easier (BMJ 2007;334:329; doi: 10.1136/bmj.39126.379479.DB). Many of Lord Crisp’s suggestions have been taken on board, with new money set aside to help with health fund to compensate public health workers who lose pension contributions when doing voluntary work abroad. The public health minister, Dawn Primarolo, said, “Our health service workers who volunteer can really make a difference in developing countries. And there are huge gains for the UK health service. Staff who volunteer get unique opportunities to develop their skills—new skills which they can put to use in the NHS when they come home.” Lord Crisp said, “I am delighted that my report, Global Health Partnerships, . . .


Department of Health officials have denied accusations that they were “taken for a ride” by the BMA over the new GP contract. MPs on the House of Commons Committee of Public Accounts quizzed health department officials last week as part of their inquiry into the National Audit Office’s report on pay modernisation for GP services in England, published in February (BMJ 2008;336:465, 1 Mar; doi: 10.1136/bmj.39504.525301.4E). Committee chairman Edward Leigh, Conservative MP for Gainsborough, quoted figures from the report when asking questions of witness David Nicholson, NHS chief executive. Mr Nicholson said that “£1.4bn of that wasn’t actually extra money paid by the tax payer for the contract; it was based on a miscalculation and an estimate of the amount of . . .


Government targets to reduce health inequalities in England might be measuring the wrong things, and the means to tackle the problem will emerge only over a long period, MPs have been told. Public health experts told MPs on the parliamentary select committee on health last week, as part of its inquiry into health inequalities, why they thought so little progress had been made so far. MPs asked why health inequalities have continued to grow, despite government efforts in its 2003 strategy Tackling Inequalities: A Programme for Action and despite GPs achieving health targets set out in their contract. Hilary Graham, professor of health sciences at the University of York, giving evidence, said, “The targets are quite short term—2010 for the health inequality ones—and, to have an impact on a very deep seated problem like inequalities in health, [this] is too short a time to expect a major impact on health . . .


A new report is calling for changes in the conduct of clinical trials in the United States to reduce disparities of age, sex, race, and comorbidity. The goal is to give a more representative picture of the benefits and risks of a treatment across the entire population but particularly among those who bear the greatest burden of the morbidity. The eliminating disparities in clinical trials (EDICT) initiative was conducted over two years by the Baylor College of Medicine in Houston and the Intercultural Cancer Council. It is part of an ongoing four year project to reduce barriers to participation in trials. The report of the initiative was released on 1 April in Washington, DC. The report describes itself as a “nationwide call to action . . . that removes the barriers to clinical trial participation and advances educa-
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HIV vaccine research should turn away from clinical trials and refocus instead on more basic studies, a meeting in Bethesda, Maryland, decided last week. “Despite hundreds and hundreds of millions of dollars, the reality in 2008 is that an HIV vaccine clearly remains beyond our grasp,” said Warner Greene, director of the Gladstone Institute of Virology and Immunology at the University of California, San Francisco, at the opening session. Last autumn a second candidate for an HIV vaccine failed. Although few expected it to protect against infection, the hope had been that it might bolster immune defences and result in slower progression of disease in people who became infected. The shock was that those who received the vaccine appeared to be slightly more likely to become infected with HIV than people who received a placebo. The trial was stopped, and researchers are still analysing the data to try to understand . . .


The current system of continuing health education—sponsored largely by an industry with a vested interest in promoting its products—is unacceptable to self-regulated health professionals, says the journal of the Canadian Medical Association. The CMAJ editorial says that health professionals should take over medical education and base it on their needs and those of their patients (doi: 10.1503/cmaj.080317). “It is time to stop the pharma-driven ‘free lunch’ approach and place our continuing medical education system firmly in the hands of unbiased and qualified people, not corpora-
tions whose main concern is the bottom line,” says the editorial, written by a team under the byline of the journal’s editor in chief, Paul Hebert. It continues: “To make this vision a reality, we call upon the Canadian Academies of Health Sciences, perhaps involving the University of California, San Francisco, at the opening session. Last autumn a second candidate for an HIV vaccine failed. Although few expected it to protect against infection, the hope had been that it might bolster immune defences and result in slower progression of disease in people who became infected. The shock was that those who received the vaccine appeared to be slightly more likely to become infected with HIV than people who received a placebo. The trial was stopped, and researchers are still analysing the data to try to understand . . .


Senior academics are outraged that the University of Queensland has asked an academic to apologise to a drug company for his public comments on a vaccine against human papillomavirus that was developed jointly by the university and the company. Academics at the university and elsewhere say that the request is a threat to academic freedom and warn that it raises worrying concerns about universities’ independence and ability to negotiate conflicts of interest. The request came after the company, CSL, wrote to the university’s vice chancellor complaining about comments on the radio made by Andrew Gunn, a senior lecturer in general practice. The programme dealt with the general issue of pharmaceutical marketing and briefly mentioned Gardasil, whose development has reaped millions of dollars for the university as well as public and political kudos. CSL’s director of public affairs, Rachel David, wrote: “I feel Dr Gunn’s comments are inappropriate and inconsistent with . . .


Ethiopia has set a target to increase the number of doctors practising in the country by 9000 in four years to fill an acute shortage of medical staff, government officials have said. Ethiopia has just 1600 doctors serving a population of 83 million but needs a minimum of 8000, the government estimates. “We face a very criti-
cal problem. We plan to train more doctors and increase their pay. It will be a massive training [of doctors] because we have a gap of over 80%,” said Mohammed Hussein, one of Ethiopia’s assistant health ministers, at a recent international conference in Uganda to tackle the global shortage in health workforce. Ethiopia has just 1600 doctors serving a population of 83 million but needs a minimum of 8000, the government estimates. “We face a very criti-

cal problem. We plan to train more doctors and increase their pay. It will be a massive training [of doctors] because we have a gap of over 80%,” said Mohammed Hussein, one of Ethiopia’s assistant health ministers, at a recent international conference in Uganda to tackle the global shortage in health workforce. Ethiopian doctors have been leaving the country to earn better salaries offered in the United States and some rich African countries, such as Botswana. The aim of the conference, which was organised by the Global Health Workforce Alliance, was to draft strategies . . .


The European Food Safety Authority has rejected suggestions in a study by researchers at Southampton University last year of a link between hyperactivity in children and two mixtures of food colours and the pres-
servative sodium benzoate (Lancet 2007;370:1560-7; doi: 10.1016/S0140-6736(07)61306-3). In a highly criti-
cal assessment, the authority points to considerable uncertainties, lack of consistency, and absence of in-
formation in the study, which was commissioned by the UK Food Standards Agency. As a result, the author-
ity, which advises the European Union on food safety, maintained that there is no basis for changing present recommendations on the acceptable daily intake of the food colours or sodium benzoate. After a request from the European Commission, the Parma based authority asked its panel on food additives, flavourings, processing aids, and food contact materials to assess the study’s findings that the colourings and preservative in the diet led to more hyperactivity in 3 . . .
Cumulative prevalence of microalbuminuria was 25.7% (95% confidence interval 21.3% to 30.1%) after 10 years of diabetes and 50.7% (40.5% to 60.9%) after 19 years of diabetes and 5182 patient years of follow-up. The only modifiable adjusted predictor for microalbuminuria was high HbA1c concentrations (hazard ratio per 1% rise in HbA1c 1.39, 1.27 to 1.52). Blood pressure and history of smoking were not predictors. Microalbuminuria was persistent in 48% of patients. Cumulative prevalence of progression from microalbuminuria to macroalbuminuria was 13.9% (12.9% to 14.9%); progression occurred at a mean age of 18.5 (5.8) years. Although the sample size was small, modifiable predictors of macroalbuminuria were higher HbA1c levels and both persistent and intermittent microalbuminuria (hazard ratios 1.42 (1.22 to 1.78), 27.72 (7.99 to 96.12), and 8.76 (2.44 to 31.44), respectively). In childhood onset type 1 diabetes, the only modifiable predictors were poor glycaemic control for the development of microalbuminuria and poor control and microalbuminuria (both persistent and intermittent) for progression to macroalbuminuria. Risk for macroalbuminuria is similar to that observed in cohorts with adult onset disease but as it occurs in young adult life early intervention in normotensive adolescents might be needed to improve prognosis.

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A nurse and physiotherapist each worked for 25 hours a week for three months in all intervention wards. They provided a targeted multifactorial intervention that included a risk assessment of falls, staff and patient education, drug review, modification of bedside and ward environments, an exercise programme, and alarms for selected patients. Intervention and control wards were similar at baseline for previous rates of falls and individual patient characteristics. Overall, 381 falls occurred during the study. No difference was found in fall rates during follow-up between intervention and control wards: respectively, 9.26 falls per 1000 bed days and 9.20 falls per 1000 bed days (P=0.96). The incidence rate ratio adjusted for individual lengths of stay and previous fall rates in the ward was 0.96 (95% confidence interval 0.72 to 1.28). A targeted multifactorial falls prevention programme was not effective among older people in hospital wards with relatively short lengths of stay.


1055 patients received eflornithine for 14 days (400 mg/kg/day in adults and 600 mg/kg/day in a subgroup of 96 children). Overall, 2824 drug reactions (2.7 per patient) occurred during hospital stay. 1219 (43.2%) after the first week. Severe reactions affected 138 (13.1%) patients (mainly seizures, fever, diarrhoea, and bacterial infections), leading to 15 deaths. Children receiving higher doses did not experience increased toxicity. Follow-up data were obtained for 924 (87.6%) patients at any follow-up but for only 533 (50.5%) at 24 months. Of 924 cases followed, 16 (1.7%) died during treatment, 70 (7.6%) relapsed, 15 (1.6%) died of disease, 403 (43.6%) were confirmed cured, and 420 (45.5%) were probably cured. The probability of event free survival at 24 months was 0.88 (0.86 to 0.91). Most (65.8%, 52/79) relapses and disease related deaths occurred after 12 months. Risk factors for relapse included being male (incidence rate ratio 2.42, 1.47 to 3.97) and cerebrospinal fluid leucocytosis: 20-99x10⁹/l (1.87, 1.07 to 3.27). Higher doses did not yield better effectiveness among children (0.87 v 0.85, P=0.981). Eflornithine shows acceptable safety and effectiveness as first line treatment for human African trypanosomiasis. Relapses did occur more than 12 months after treatment. Higher doses in children were well tolerated but showed no advantage in effectiveness.


A single dose of rifampicin or placebo given to close contacts in the second month of starting the index patient’s treatment, with follow-up for four years. 18869 of the 21711 contacts (86.9%) were followed-up at four years. Ninety one of 9452 contacts in the placebo group and 59 of 9417 in the rifampicin group had developed leprosy. The overall reduction in incidence of leprosy using a single dose of rifampicin in the first two years was 57% (95% confidence interval 33% to 72%). The groups did not differ between two and four years. The overall number needed to treat (NNT) to prevent a single case of leprosy among contacts was 297 (95% confidence interval 176 to 537). Differences were found between subgroups at two years, both in reduc-
tion of incidence and in NNT. single dose of rifampicin given to contacts of patients with newly diagnosed leprosy is effective at preventing the development of clinical leprosy at two years. The effect was maintained, but no difference was seen between the placebo and rifampicin groups beyond two years.


Immunisation status at 3 years defined as “immunised with MMR,” “immunised with at least one single antigen vaccine,” and “unimmunised.” 88.6% (13 013) were immunised with MMR and 5.2% (634) had received at least one single antigen vaccine. Children were more likely to be unimmunised if they lived in a household with other children (risk ratio 1.74, 95% confidence interval 1.35 to 2.25, for those living with three or more) or a lone parent (1.31, 1.07 to 1.60) or if their mother was under 20 (1.41, 1.08 to 1.85) or over 34 at cohort child’s birth (reaching 2.34, 1.20 to 4.32, for more highly educated (1.41, 1.05 to 1.89, for a degree), not employed (1.43, 1.12 to 1.82), or self employed (1.71, 1.18 to 2.47). Use of single vaccines increased with household income (reaching 2.98, 2.05 to 4.32, for incomes and education (reaching 3.15, 1.78 to 5.58, for a degree). Children were less likely to have received single vaccines if they lived with other children (reaching 0.14, 0.07 to 0.29, for three or more), had mothers who were Indian (0.50, 0.25 to 0.99), Pakistani or Bangladeshi (0.13, 0.04 to 0.39), or black (0.31, 0.14 to 0.64), or aged under 25 (reaching 0.14, 0.05 to 0.36, for 14-19). Nearly three quarters (74.4%, 1110) of parents who did not immunise with MMR made a “conscious decision” not to immunise. Although MMR uptake in this cohort is high, a substantial proportion of children remain susceptible to avoidable infection, largely because parents consciously decide not to immunise. Social differentials in uptake could be used to inform targeted interventions to promote uptake.


Primary outcomes were relapse and overall failure resulting from primary failure or relapse. Relative risks with 95% confidence intervals were calculated and pooled with a fixed effect model. Results 30 trials and 77 treatment arms were included. Overall failure was significantly higher with doxycycline-rifampicin compared to doxycycline-streptomycin, mainly due to a higher rate of relapse (relative risk 2.80, 95% confidence interval 1.81 to 4.36; 13 trials, without heterogeneity). Results were consistent among patients with bacteraemia and complicated brucellosis. Doxycycline-streptomycin resulted in a significantly higher rate of failure than doxycycline-rifampicin-aminoglycoside (triple drug regimen) (2.50, 1.26 to 5.00; two trials). Gentamicin was not inferior to streptomycin (1.45, 0.52 to 4.00 for failure; two trials). Quinolones combined with rifampicin were significantly less effective than doxycycline combined with rifampicin or streptomycin (1.83, 1.11 to 3.02, for failure; five trials). Monotherapy was associated with a higher risk of failure than combined treatment when administered for a similar duration (2.56, 1.55 to 4.23; five trials). Treatment for six weeks or more offered an advantage over shorter treatment durations. There are significant differences in effectiveness between currently recommended treatment regimens for brucellosis. The preferred treatment should be with dual or triple regimens including an aminoglycoside.

CLINICAL REVIEW


Polymyalgia rheumatica is the most common inflammatory rheumatic disease in elderly white people, and it is a common indication for long term treatment with glucocorticosteroids in patients based in the community.1 2 Although the symptoms are very characteristic, several other autoimmune, infectious, endocrine, and malignant disorders can present with similar symptoms. The course of disease is heterogeneous and unpredictable, and giant cell arteritis is seen in about 30% of patients.3 Glucocorticosteroids rapidly improve disease symptoms in most patients but may have serious side effects. This review looks at the current understanding of diagnosis and the management of polymyalgia rheumatica. Sources and selection criteria. We searched PubMed, Embase, Scopus, Premedline, and National Institutes for Health Clinical Trials publications from 2000 to 2007 for strategies for the diagnosis and management of polymyalgia rheumatica. We found no Cochrane reviews on the subject.


Summary points

Most breast enlargement in males is due to the benign enlargement of breast tissue (gynaecomastia) Physiological gynaecomastia occurs in neonates, at puberty, and with obesity and ageing.

Gynaecomastia is due to an increased oestrogen to testosterone ratio; possible causes are many.

Treatments for painful or embarrassing gynaecomastia include an anti-oestrogen, such as tamoxifen, or surgery (liposuction or mammoplasty). One per cent of breast cancers occur in men with
higher rates in men with a family history of breast cancer or previous chest radiation. Irregular, eccentric, hard or fixed breast tissue, ulceration, nipple abnormalities, or associated adenopathy suggest breast cancer. Men typically have more advanced breast cancer at diagnosis than women; management is similar.

Breast disorders in males can be distressing for both patients and examining doctors. Patients often feel embarrassed and anxious. Although cancers are diagnosed in only about 1% of cases of male breast enlargement, practitioners may feel uncertain...