# Evidently…

Tolstoy once wrote that all happy families are exactly the same, but each unhappy family is unhappy in its own way. It is the same with individuals: **depression** means something different for each person, and what may work for one may not for another. We have 2 basic treatment modalities: drugs that help the brain to feel good, and psychological treatments that teach depressed patients how to cope and escape negative thoughts. Generally people do best when offered both, as shown by a systematic review in *Arch Gen Psychiatry* 2004;**61**: 714–9. Two recent studies look at the role of the **telephone** in the management of depression: a cluster randomised trial in *BMJ* 2004;**329**:602, in which clinicians were available for telephone advice under the supervision of a psychiatrist, and a 3-group RCT, also from the US but with a different design, in *JAMA* 2004;**292**:935–42. Both showed the value of telephone support, especially in the early stages of treatment. Another trial which used cognitive behavioural therapy by phone showed its value in **insomnia** (*J Consult Clin Psychol* 2004;**72**:653–9): patients were not, however, encouraged to phone the research team at 3 am when they could not get to sleep.

The place to find out about **nicotine replacement for smoking cessation** is the Cochrane review (2004;(3): CD000146). A couple of recent studies have looked at the value of **add-on bupropion**. Small randomised trials failed to detect an additional effect either in adolescent smokers (*J Consult Clin Psychol* 2004;**72**:729–35) or in a mainly elderly group (*Arch Intern Med* 2004;**164**:1797–803). On the other hand, **nortriptyline** (25 mg titrated up to 75 mg) plus transdermal nicotine did show an increased cessation rate in a bigger RCT (*Arch Intern Med* 2004; 164:2229–33). Time to try out the cheaper drug more often?

The readiness of many frontline doctors to give out **antibiotics** (I plead guilty) flies in the face of the evidence in many areas, such as sore throat (Cochrane review CD000023), otitis media, and most other respiratory tract infections. By giving parents or patients a prescription for antibiotics, but suggesting **delayed use**, are we just passing the buck, or is this a safe and effective way of reducing overuse of antibiotics? This difficult area is well explored in a new Cochrane review (CD004417): more RCTs with symptom endpoints are needed. How much easier it would be if we had some clear markers to tell us when a problem is due to bacterial infection. In **acute conjunctivitis**, a Dutch cohort study finds that glued eyes in the morning predict this, whereas itch and recurrent conjunctivitis point elsewhere (*BMJ* 2004;**329**:206). It is not so straightforward for internal infections—**procalcitonin** is attracting interest as a rapid serological marker for serious bacterial infection (see *Pediatrics* 2004;**114**:e249–54, investigating pyelonephritis), but its use in primary care needs much more investigation.

There is one illness which proclaims its non-bacterial origin simply by its sound—the seal-like bark of **croup.** I should add that even in these days of universal Hib vaccine, it is still worth keeping the remote possibility of epiglottitis in mind; but for mild croup, the safe and effective intervention is a single dose of **oral corticosteroid** (Canadian RCT, *N Engl J Med* 2004;**351**:1306–13).

Looking at follow up in the big randomised therapeutic trials in **chronic heart failure** is a gloomy business: within a few years (and often a much shorter time), all the patients are dead. The last few years have seen a welcome profusion of trials of **managed care** for heart failure, and most show immediate improvements in quality of life as well as survival. But this malignant process tends to catch up, so that benefits decline in the longer term (*Heart* 2004;**90**:1010–5). If you want to keep heart failure patients living longer, then **β adrenergic blockers** are probably even more important than modifiers of the renin-angiotensin-aldosterone system. They can generally be well tolerated even in elderly patients (subgroup analysis of the MERIT-HF study, using slow release metoprolol, *Eur Heart J* 2004;**25**:1300–9).

Once you have **knee osteoarthritis**, you are stuck with it until you get a new knee. Of course, the amount of pain will vary due to numerous factors, so **topical non-steroidal anti-inflammatory drugs** (NSAIDs) may not be entirely useless; but don't expect them to work for more than 2 weeks (meta-analysis of RCTs, *BMJ* 2004;**329**:324). Two weeks is not a very long time, so a trial favouring **oral ibuprofen** over paracetamol (acetaminophen) over that period (*Ann Rheum Dis* 2004;63:1028–34) has limited value, whereas a crossover trial of **celecoxib** versus paracetamol or placebo (*Ann Rheum Dis* 2004;**63**:931–9) gave the treatments for 6 weeks and favoured celecoxib. The issue of whether paracetamol has any effect at all in osteoarthritis is the subject of meta-analysis in *Ann Rheum Dis* 2004:**63**:901–7, which concludes that it has.

Brave doctors regularly perform the **Epley manoeuvre**, which can have dramatic effects in **benign positional vertigo** (BPV), including sudden vomiting and/or cure. A group of German researchers, perhaps concerned about their footwear and their carpets, taught patients to perform the manoeuvre themselves and compared them with a group taught the Sermont manoeuvre. The Epley worked better, whether or not it was correctly carried out. Look up *Neurology* 2004;**63**:150–2, to keep your BPV patients grateful and your consulting room fragrant.

All studies except those published in *Arch Intern Med* appear on the "Other articles noted" list.

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