Heart failure is a condition that eventually kills most of those who have it, and at the very least causes misery, anxiety, and repeated visits to hospital. The evidence base for treatment has been built up by adding one drug class to another, so patients are usually on a long list of medication about which many have little understanding. Short term outcomes can be improved by patient education, as in a trial of 223 patients with systolic heart failure who were randomised to receive 1 hour of nurse-educator teaching at the time of hospital discharge (Circulation 2005;111:179–85). At 6 months, the intervention group totalled fewer days dead or in hospital, and showed reduced costs. A larger community-based trial (n = 1069) in all types of heart failure used a telephonic disease management programme and showed an average 76 days longer survival at 18 months, but no improvement in objective measures of function, hospitalisation, or healthcare costs (Circulation 2004;110:3518–26). Looking beyond heart failure, a randomised trial of home medication review in patients over 80 taking >2 drugs in the UK showed an actual increase in hospital admission and no benefits in quality of life or survival (BMJ 2005;330:293).

Does the thought of sorting out an elderly patient with syncope make you feel faint? Specialist units seem to do best: at the Mayo clinic, patients (mean age 64 y) were far more likely to end up with a firm diagnosis if they were randomised to a syncope evaluation unit (Circulation 2004;110:3636–45) and were a little more likely to survive the next 2 years. In a descriptive study from the UK (J Am Geriatr Soc 2005;53:74–8), older patients with drop attacks (mean age 77.4 y) were found to have a high incidence of soft tissue injuries and fractures, and careful investigation found an attributable diagnosis in 90%, generally cardiovascular or neurological.

Rarely does a day go by in general practice without the question of what to do about otitis media. In the acute situation there is the temptation to prescribe antibiotics—should we resist? A Canadian randomised placebo controlled trial of amoxicillin (CMAJ 2005;172:335–41) shows that this old friend actually works—a bit. There was less pain and fever in the first 2 days, and significantly higher resolution of symptoms at 2 weeks. And if a middle ear effusion follows, impairing hearing, when should we be thinking of grommets (ventilation tubes)? There is no clear answer in the Cochrane Review (2005:CD001801): very modest short term improvements and no long term benefits.

Hormone replacement therapy, not long ago the elixir of life for postmenopausal women, is now deeply out of fashion, even as prevention for osteoporosis: but it might be making a small come-back, in the form of tiny doses of transdermal oestradiol (0.014 mg/d). This amount of unopposed oestradiol did not cause endometrial hyperplasia in a double blind RCT in 417 women 60–80 years of age (Obstet Gynecol 2004;104:443–51), and did improve bone mineral density. And thinking of osteoporosis, don’t forget androgen deprived men—a cohort study of those who survived >5 years after androgen suppression treatment for prostate cancer shows that there is a dose related increase in fractures (N Engl J Med 2005;352:154–64).

If you want your child to avoid atopic wheezing, do you fill your house with pets, dirt, and siblings, or do you take the route of obsessive cleanliness? There is some evidence for the first strategy, but little for the second: a British cohort study (Thorax 2004;59:855–61) followed 552 British children from birth to 5.5 years and found that in susceptible children, very low levels of exposure could trigger an IgE response, which was little influenced by further increases.

A big Danish study (Am J Epidemiol 2004;160:661–7) looked prospectively at pregnancy detected by urine HCG and compared it with monthly diary entries of alcohol intake from both partners. Ten or more drinks per week increased the risk of miscarriage substantially—male intake being, if anything, a stronger risk.

How often should I use the cream, doctor? If it’s a topical corticosteroid for atopic eczema, the chances are that you will get the same result from 1 application daily as from more, according to a systematic review and economic evaluation in Health Technol Assess 2004;8:i,iv, 1–120.

Dandruff has provided the inspiration for some classic shampoo advertisements, but can we believe the science? Ciclopinox is a new antipityrosporal agent and was put through its paces both for treatment and prevention of seborrhoeic dermatitis of the scalp in a double blinded multinational trial (Arch Dermatol 2005;141:47–52). The NNS (number needed to shampoo) is about 5.

The heroic age of sleep deprived doctors has come to an end on one side of the Atlantic with the European Working Time Directive, but in many places in the US, interns are not so lucky. Maybe their lot will improve following a study in N Engl J Med 2004;351:1838–48 that shows a reduction in serious medical errors after their intensive care shifts were made shorter. In the meantime, avoid them when they are driving home: when it comes to the crunch, they have more car accidents (N Engl J Med 2005;352:125–34).

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