



Cancer clinical trials and publication bias

Failure to publish the results of large clinical trials can lead to bias in the literature and may contribute to inappropriate clinical decisions. Krzyzanowska and colleagues identified abstracts of large phase 3 clinical trials in the proceedings of the annual American Society of Clinical Oncology meetings from 1989 through 1998 and found that the probability of full publication by 5 years was significantly greater for trials with significant results than for trials with nonsignificant results. Trials with oral or plenary presentation were published sooner than those not presented, and trials with pharmaceutical sponsorship were published sooner than cooperative group trials or those for which sponsorship was not specified.

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General practice across the Tasman (and elsewhere)?

All is not well with general practice. Australian GPs along with their international colleagues, protest that they are undervalued, overworked and no longer in control. "They feel like hamsters on a treadmill. They must run faster just to stay still...The result of the wheel going faster is not only a reduction in quality of care, but also a reduction in professional satisfaction and an increase in burnout amongst doctors." Assemble any group of Australian GPs and talk will soon turn to how recent Federal Government policies regulating general practice have reduced their fiscal autonomy, increased red tape, eroded their professional time, and diminished the quality of their clinical care.

However, a more ominous threat to the future of general practice is its increasing unattractiveness as a vocation. Junior doctors in Australia and North America are increasingly dissatisfied with general practice, and are voting with their feet.

Anecdotal reasons advanced for this discontent include the low remuneration and lack of prestige of general practice, the demands of practice that may preclude a life beyond medicine, and the advent of competing players in the delivery of primary care, such as nurse or alternative medicine practitioners.

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Kurt Semm, RIP 16/7/2003 – death of a pioneer

On 13 September 1980 gynaecologist Professor Kurt Semm performed the world's first laparoscopic appendicectomy at the University of Kiel in Germany. When Semm, director of the department of obstetrics and gynaecology at Kiel University Hospital, later told a surgical meeting what he had done, the president of the German Surgical Society called for his suspension. The scepticism was not just confined to Germany. When Semm tried to publish his paper on the first laparoscopic appendicectomy it was rejected because the technique reported was assumed to be unethical.

At the time, diagnostic laparoscopies were well accepted, but surgical attempts – apart from gynaecological sterilisation – were considered experimental and therefore unethical. It seemed unthinkable that surgeons should not have a good view of the entire operation site or have direct access and manual contact with the organs that they wished to treat, even if Semm's method might mean smaller incisions and reduced tissue damage. When Semm tried to convince his colleagues from other surgical disciplines in Kiel and elsewhere of the advantages of laparoscopic surgery – for instance, for gall bladder removal – they were mostly sceptical or apprehensive. Some of his co-workers asked him to have a brain scan, suspecting brain damage or a brain disease in someone who would attempt such an extraordinarily dangerous procedure.

Nowadays minimally invasive surgery is a scientifically established standard procedure for certain operations.

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Long-term risk of breast cancer in Hodgkin Disease

Treatment of Hodgkin Disease (HD) represents one of the major medical successes of the 20th century. Fifty years ago, the typical patient survived only a few years, whereas the current 5-year relative survival rate is 85%. In the United States alone, approximately 120 000 survivors of HD are at risk for the serious late sequelae of curative therapies, including the occurrence of new primary cancers.

The leading cause of death in long-term survivors of Hodgkin Disease (HD) is second malignant neoplasms. In this case-control study of breast cancer in a cohort of female 1-year survivors of HD diagnosed at age 30 years or younger, Travis and colleagues found that treatment with radiation alone at doses of 4 Gy or more delivered to the breast was associated with a 3.2-fold increased risk of breast cancer compared with patients who received lower doses of radiation and no alkylating agents. Treatment with combined radiotherapy and alkylating agents was associated with a 1.4-fold increased risk, whereas treatment with alkylating agents alone was associated with a reduced risk of breast cancer. Ovarian damage by either radiation or chemotherapy was associated with decreased risk.

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Deja vu – limits imposed on residents' work hours

On July 1, 2003, something came to pass in the USA that had been warmly anticipated by many medical students and residents – and dreaded by faculty and programme directors. The Accreditation Council on Graduate Medical Education (ACGME), the private body that accredits all 7800 US residency programmes, imposed new residency work hour limits.

The guidelines generally limit on-duty time to 80 hours a week and require 10 hours off between duty periods, and one continuous 24-hour period off every 7 days. The guidelines also prohibit overnight in-house call more than once in three nights, and ban residents from working more than 24 consecutive hours.

In the past residents in internal medicine programmes might work 100–110 hours a week with every third night on call, and surgical residents might work 120 hours a week with every other night on call.

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