



George Bernard Shaw and “the doctor’s dilemma”

George Bernard Shaw in the preface to this play savagely attacked the medical profession for its direct personal and pecuniary interest in the treatment of patients and argued that doctors could not be trusted to act in their patients’ best interests.

In an interesting editorial, Martin Van Der Weyden, the editor of the *Medical Journal of Australia*, speculates on what George Bernard Shaw would think of doctors now. As a prominent Fabian, Shaw would enthusiastically endorse Australia’s Medicare scheme and other similar national health services. He would be interested to know that Australia spends 9.8% of its gross domestic product (GDP) each year on health—much more than New Zealand and much less than the United States. And there are other points to ponder, evidence-based medicine, the impact of the pharmaceutical companies, etc, etc.

The problems may be different but doctors still have dilemmas.

Med J Aust 2006;185:585–6

Intravenous versus oral antibiotics in severe community acquired pneumonia

When patients are first admitted to hospital with community acquired pneumonia, antibiotics are usually given intravenously to provide optimal concentrations in the tissues. The question then arises—when is it appropriate to change to the oral route?

In this trial from Holland, patients were given 3 days of treatment with intravenous antibiotics, followed (when clinically stable) by oral antibiotics or by 7 days of intravenous antibiotics. Their conclusion was that early switch from intravenous to oral antibiotics in patients with community acquired pneumonia is safe and decreases length of hospital stay by 2 days. Patients excluded were those sick enough to be admitted to Intensive Care Units.

The accompanying editorial (written by two New Zealand clinicians) applauds the study but noted that the trial used overly conservative discharge practices, and it would have been safe to shorten length of stay further for most patients. One would have to say also that 7 days of intravenous antibiotics as the reference arm is rather heavy-handed.

BMJ 2006;333:1181–2 & 1193–5

Hip fracture and long-term proton pump inhibitor therapy?

Clinicians are aware that the use of proton pump inhibitors (PPIs) has revolutionized the management of acid-related diseases such as gastroesophageal reflux disease (GERD)—or GORD as we prefer to call it.

Apparently there is some evidence that PPI therapy may decrease insoluble calcium absorption or bone density. On the other hand, there is evidence that omeprazole may decrease bone resorption by inhibiting osteoclastic activity.

Hence this nested case-control study which evaluated the incidence of hip fracture in subjects older than 50 years in relationship to their usage or non-usage of PPI therapy. They report that the adjusted odds ratio (AOR) for hip fracture associated with more than 1 year of PPI therapy was 1.44 rising to 1.59 after 4 years of treatment. In view of their findings they recommend clinicians to use the lowest effective dose for patients with appropriate indications in the elderly.

JAMA 2006;296:2947–53

Persistent middle-ear effusion and developmental impairment?

Developmental impairment in children have been attributed to persistent middle-ear effusion in their early years of life.

Myringotomy with insertion of tympanostomy tubes in order to clear the effusion and restore hearing acuity to a normal level has been claimed to be the solution; this view has been disputed by a collaboration of otolaryngologists in the USA who have published on the topic over the last 5 years.

In their latest study of a cohort of 6350 infants, they noted that before 3 years of age, 429 children with persistent effusion were randomly assigned to undergo the insertion of tympanostomy tubes either promptly or up to 9 months later if effusion persisted. Subsequently, using 48 developmental measures, they assessed literacy, attention, social skills, and academic achievement in 391 of these children at 9 to 11 years of age. The group treated early did no better. So they recommend, in otherwise healthy children, that watchful waiting for at least 6 additional months when effusion is bilateral (and for at least 9 additional months when effusion is unilateral) is the preferred management option. An editorial commentator endorses their opinion.

N Engl Med 2007;356:248–61 & 300–2

Variation in gastrointestinal endoscopy reports

Gastrointestinal endoscopy has proven to be of great use in the diagnosis of upper and lower gastrointestinal disease. Non-gastroenterologists regard endoscopy reports as the gold standard, but how do gastroenterologists regard them?

In this study, all gastroscopies and colonoscopies performed in two UK teaching hospitals over a period of one year were audited to investigate whether endoscopic reporting of endoscopies and colonoscopies by different endoscopists is consistent.

Endoscopic videos of 1814 colonoscopies and 2127 gastroscopies were reviewed. Somewhat disconcertingly the frequency of reporting common diagnoses was variable and the differences between specialist endoscopists were highly significant, including for important conditions such as peptic ulceration (range 2–10%, $p=0.001$) and colonic polyps (16–45%, $p<0.0001$). And their solution—more emphasis on interpretation in training endoscopists.

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