



Feminisation of the medical workforce

We have all noted this in recent years but what about some facts? A recent detailed analysis by the Royal College of Physicians shows that 40% of all doctors in Britain are women. Among general practitioners (GPs), 42% are female. By 2013, says the College, a majority of GPs will be women, and by 2017 there will also be a majority of women doctors in hospitals. It is also noted that women account for 60% of all medical students in Britain, a figure mirrored in New Zealand—your scribe finds his territorial figure to be 59%.

Clearly there are great benefits arising from more women in medicine. However, and a very important however, there will be a profound problem arising unless training numbers are increased to allow for the biological events inevitable in the feminine workforce.

The Guardian Weekly, 12/6/09, p14.

Intensive insulin therapy for the critically ill

Hyperglycemia is associated with adverse outcomes, including increased mortality, in acutely ill patients. A number of randomised trials have tested the hypothesis that intensive insulin therapy might reduce in-hospital mortality. One, in particular, demonstrates that intensive insulin therapy, targeting a blood glucose concentration of 4.4–6.1 mmol/L, significantly reduced in-hospital mortality.

This trial involved patients in a surgical Intensive Care Unit (ICU). The researchers in this abstracted paper speculate on whether this conclusion has wider merit. Their meta-analysis included 26 trials which involved 13,567 patients. The overall interpretation of their meta-analysis was that intensive insulin therapy significantly increased the risk of hypoglycemia and conferred no overall mortality benefit among critically ill patients. However, it is interesting to note that benefit was noted in the 5 surgical ICU reports where the Odds Ratio (OR) for death was 0.63 (cf OR 0.93 in all 26 trials).

CMAJ 2009;180(8):821–7.

Heart failure therapy guided by N-terminal brain natriuretic peptide (BNP)?

The proposition that BNP levels might enable clinicians to manage heart failure more effectively was first raised by New Zealand researchers in 2000. The paper reported on in this abstract is the fifth randomised trial evaluating the issue of BNP versus symptoms in the management of heart failure. 499 Swiss patients aged 60 years or older with systolic heart failure (ejection fraction $\leq 45\%$) were randomised to symptom or BNP-guided therapy.

Overall, clinical outcome or quality of life was similar in each arm, but age group sub-analysis showed that BNP guided treatment improved outcome in patients aged 60-75 years but not in the 75 years or older group. A reviewer of the paper notes information from the 5 trials is that the strategy of using N-terminal BNP-guided therapy appears safe in patients younger than 75 years (i.e. no excess of hypotension, renal failure, or hyperkalemia) and some data suggest a modest reduction in mortality for some patients.

JAMA 2009;301:383-92 & 432-4.

Cervical cancer smear tests for women after age 50 years?

Some believe that women with a history of negative smear tests can cease such testing when they reach 50 years of age. Is this sound advice? This report from the Netherlands is based on their national data register. The data presented compares the incidence of cervical cancer in women who have had three previous consecutive negative smears and were either aged 30-44 years or 45-54 years of age. The cohorts were large, 218,847 and 445,382 respectively, and the follow-up was 10 years.

Cancer incidence was 41/100,000 in the younger group and 36/100,000 in the older women ($p=0.48$). So even after several negative smear results, age is not a good discriminative factor for early cessation of screening.

BMJ 2009;338:1058-61.

Type 2 diabetes and coronary artery disease

The authors of this paper note that the optimal treatment for patients with both type 2 diabetes mellitus and stable ischemic heart disease has not been established. This multi-centre trial attempts to solve this problem. 2368 patients with both type 2 diabetes and heart disease were randomly assigned to undergo either prompt revascularisation with intensive medical therapy or intensive medical therapy alone and to undergo either insulin or oral hypoglycaemic drug treatment.

Randomisation was stratified according to the choice of percutaneous coronary intervention (PCI) or coronary-artery bypass grafting (CABG) as the more appropriate intervention. At 5 year follow-up there was no significant difference in the rates of death and major cardiovascular events between patients undergoing prompt revascularisation and those undergoing medical therapy, or between those taking insulin or those being treated with oral hypoglycaemic drugs.

N Engl J Med 2009;360:2503-15.