

All you need to read in the other general medical journals
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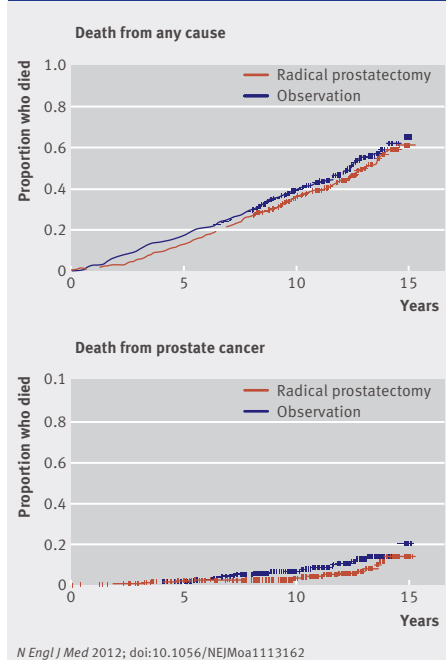


“The arrival of interferon led directly to my becoming aware of the very limited evidence base for many major changes in medical practice”

Richard Lehman's blog at www.bmj.com/blogs

Who needs radical prostatectomy for localised prostate cancer?

Mortality after prostate cancer diagnosis



A trial comparing radical prostatectomy with simple observation for men with localised prostate cancer has once more tipped the balance of evidence away from surgery for many men. Radical prostatectomy did not significantly reduce mortality during 10 years of follow-up (171/364 (47%) v 183/367 (49.9%), hazard ratio 0.88 (95% CI 0.71 to 1.08)) and made no significant difference to risk of death from prostate cancer or its treatment. The men had localised disease (half the tumours were impalpable) and a median prostate specific antigen concentration of 7.8 µg/L. Four fifths of the men who had surgery were unable to have erections afterwards (231/285 (81%) v 124/281 (44%), $P < 0.001$), and one in six was incontinent (49/287 (17%) v 18/284 (6%), $P < 0.001$).

The trial was too small to be conclusive, says a linked editorial (doi:10.1056/NEJMe1205012), but radical prostatectomy is beginning to look like the wrong choice for many men, particularly those with low risk disease (early stage, low grade tumours, and low concentrations of prostate specific antigen). Radical prostatectomy will be the right choice for others, however, and the task ahead is to find out exactly who they are. These are the men with lethal cancers, who need definitive

treatment. Current diagnostic strategies still aren't good enough to differentiate cancers that could kill from those that probably won't, and researchers are working on smarter biomarkers to replace or complement prostate specific antigen. The ultimate goal is to biopsy fewer men and treat aggressively only those who need it. Active surveillance is another option for men who don't.

N Engl J Med 2012; doi:10.1056/NEJMoa1113162

Oral immunotherapy helps some children with egg allergy

Children with egg allergies face a lifetime of trying to avoid a ubiquitous and often hidden ingredient. Treatment options are limited, but a preliminary trial suggests that a substantial proportion of children can be desensitised with a course of oral immunotherapy using powdered egg white. Thirty out of 40 children (75%) successfully passed a food challenge after 22 months of taking a small dose of the egg white every day. None of the 15 controls passed the first food challenge at 10 months, and their placebos were stopped.

Desensitisation raises the threshold of tolerance and helps protect children who accidentally eat egg. What parents really want is tolerance that lasts and is powerful enough to allow their children a normal diet for good. In this trial, children stopped their immunotherapy after 22 months and lived an egg-free life for four to six weeks before being challenged again, this time with 10 g of powdered egg white followed by a whole cooked egg. Eleven of the 40 (28%) children who started immunotherapy successfully passed all challenges, including the whole egg. These children continued eating egg in their daily diet for another year with no adverse events.

So “sustained unresponsiveness” to egg is possible, say the authors. Immunotherapy caused no serious adverse events, although children complained of oral or pharyngeal symptoms after a quarter of doses. Five children stopped immunotherapy early because of allergic reactions.

N Engl J Med 2012; doi:10.1056/NEJMoa1200435

Good ideas can have unintended consequences

Efforts to reduce maternal and neonatal mortality in low income countries often include a component to speed up transport of obstetric emergencies

from home to hospital. A systematic search for controlled studies testing these components found plenty of good ideas—including better vehicles, better communications, skilled birth companions to accompany women on the journey, and reorganisation of services so that women in late pregnancy can be housed close to obstetric facilities. The researchers did not, however, find a clear impact on maternal deaths, stillbirths, or neonatal deaths. Results were inconsistent, both within and between studies, and many tested complex interventions that included improvements in care. In the four trials reporting a reduction in neonatal deaths, researchers weren't able to isolate the effects of rapid referral from other changes.

Maternity waiting homes were among the most promising options. Three studies suggested they could reduce stillbirths, although the reductions were significant in only one. Such homes are already widespread and should be better evaluated. If they do work, we don't yet know how.

The review synthesised evidence from 19 studies, and few practical messages emerged, except perhaps for a warning that good ideas can have unintended consequences. When researchers gave emergency bicycles with stretchers to villagers in Malawi, women in labour refused to use them, and the proportion of women delivering in hospital fell significantly.

PLoS Med 2012; doi:10.1371/journal.pmed.1001264

Hospital food contains an unhealthy amount of salt

Hospitals are often criticised for their woefully unhealthy food. The latest bad news comes from a study which found excessive amounts of salt in meals served to inpatients at three Canadian hospitals. Four fifths of regular hospital menus and almost all menus designed for people with diabetes exceeded the upper limit of sodium intake set by the US Institute of Medicine. An average regular menu contained more than 3 g per day of sodium. An average diabetic menu contained 3.6 g. Researchers even found problems with reduced salt menus, particularly menus allowing patients a choice. They analysed 2318 menus between November 2010 and August 2011.

Hospitals really must try harder, says a linked comment (doi:10.1001/archinternmed.2012.3466). Too much salt is a well known hazard to health and can be particularly

dangerous for people with heart failure, liver failure, and kidney failure. Hospital food should be part of a therapeutic environment that cures the sick and promotes good health for both patients and staff. Hospitals took a stand on smoking indoors 20 years ago and governments followed. Hospitals should now be leading the campaign against unhealthy food, not serving meals that are a direct assault on their core purpose.

Arch Intern Med 2012; doi:10.1001/archinternmed.2012.2368

Inactivity causes almost one in 10 premature deaths worldwide

Physical inactivity is responsible for close to one in 10 premature deaths worldwide (9% (range 5.1–12.5%)), say researchers. They also estimate that exercising less than recommended by the World Health Organization causes 6% (3.2–7.8%) of all coronary heart disease, 7% (3.9–9.6%) of type 2 diabetes, 10% (5.7–13.8%) of colon cancers, and 10% (5.6–14.1%) of breast cancers globally.

The estimates are from population attributable fractions, or the percentage of a disease that would be avoided if all inactive people became active. The researchers used data on prevalence of inactivity from WHO and estimates of associated risks from published meta-analyses. Their final

figures are conservative but suggest that physical inactivity kills as many people worldwide as smoking or obesity. If everyone in the world moved (briskly) as much as WHO says they should, average life expectancy would increase by roughly eight months (0.68 (range 0.41–0.95) years). Inactive people would gain even more.

Doctors, public health authorities, and governments already tell people that exercise is good for them. Stressing the benefits does not work, says a linked comment (doi:10.1016/S0140-6736(12)60954-4). It's time to start emphasising that inactivity kills instead, a hardline approach more familiar in tobacco control. We should start by overturning the idea that doing nothing is normal: inactivity causes colossal damage to public health, and deserves the same attention and resources as smoking.

Lancet 2012; doi:10.1016/S0140-6736(12)61031-9

Consider human papillomavirus screening for women with HIV

US guidelines recommend that women infected with HIV have annual cytology to screen for cervical cancer. Women without HIV are screened less often, with a combination of cytology and tests for human papillomavirus (HPV). Are the differences justified?

In a recent comparative study women with HIV infection and a negative cervical screen that included an HPV test seemed to have the same risk of cervical lesions over time as uninfected women with the same negative screen. The authors tracked two cohorts of women with normal cervical cytology and a cervicovaginal lavage clear of HPV infection. All the women in one cohort had HIV infection. The estimated cumulative incidence for cervical intraepithelial neoplasia grade II or worse was 5% (6/145, 95% CI 1% to 8%) for women with HIV and 5% (9/219, 2% to 8%) for uninfected controls during five years of follow-up. One woman in each cohort developed cervical intraepithelial neoplasia grade III. None developed cervical cancer.

The women in both cohorts had cervical smear tests twice a year and a cervical biopsy if indicated. Just under half the women with HIV were taking highly active antiretroviral therapy (HAART), and four fifths had CD4 cell counts >350 cells $\times 10^6/L$ at baseline.

Guideline committees might think about extending HPV testing to women with HIV and possibly increasing the screening interval for women with a negative result, say the authors. But confirmatory studies, preferably randomised trials, should be done first.

JAMA 2012;308:362-9

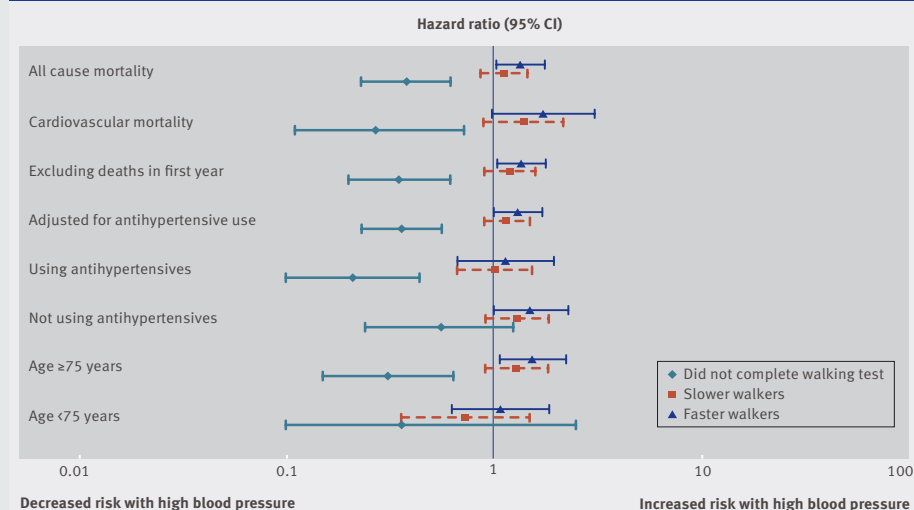
Cite this as: *BMJ* 2012;345:e4981

Another use for tests of walking speed in older adults

Walking speed is emerging as an important measure of frailty in older adults. It's easy to measure, reproducible, and associated with survival. Walking speed might also help identify older adults who need treatment for high blood pressure, according to an observational study from the US. In a nationally representative cohort of 2340 adults aged ≥ 65 years, systolic blood pressure of ≥ 140 mm Hg predicted mortality in faster walkers (hazard ratio 1.35 (95% CI 1.03 to 1.77)) but not in slower walkers (hazard ratio 1.12 (0.87 to 1.45)). High blood pressure seemed protective in the small subset of adults who failed to complete the short walking test.

Doctors disagree about how to manage blood pressure in older adults, says a linked comment (doi:10.1001/archinternmed.2012.2642). Many are reluctant to accept that high blood pressure isn't always a bad sign. It may be a bad sign for those lucky enough to be well and physically fit (the kind of adults recruited into trials of antihypertensive drugs). But the direct association between blood pressure and mortality breaks down, or

Association of high blood pressure and mortality by walking speed



Arch Intern Med 2012; doi:10.1001/archinternmed.2012.2555

even reverses in older adults who are unable to walk 1.8 miles/h for 20 feet (0.8 m/s for 6 m)—the defining threshold used in this study.

The new data reinforce walking speed as a useful measure of frailty, says the comment, and remind us that there is no such thing as an average older person when it comes

to blood pressure. Guidelines for treatment based on age alone will miss the mark and risk overtreating frail adults who may need their high blood pressure to perfuse vital organs, including the heart.

Arch Intern Med 2012; doi:10.1001/archinternmed.2012.2555