SHORT CUTS

ALL YOU NEED TO READ IN THE OTHER GENERAL JOURNALS

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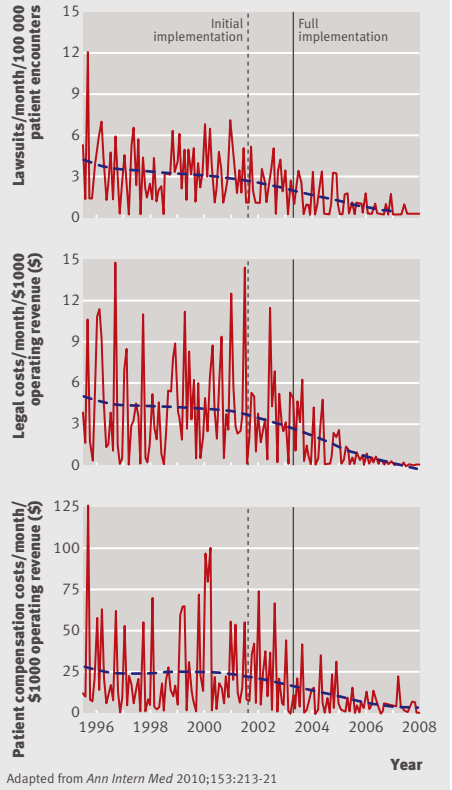
It pays to handle medical errors ethically

In 2001, the University of Michigan Health System changed how it dealt with patients' claims for compensation. Instead of the old practice—where a claims management committee reviewed the case and recommended settling or going to trial—the new practice meant that all claims underwent an internal inquiry. If a medical error was identified then fault was admitted and compensation offered; if no error was found, the claim was rejected, arguments presented, and the stand vigorously defended.

This is in line with medical ethics and the principles of patient safety, but the practice is far from widespread. Only one centre had previously reported data on claims and costs after a similar procedure was implemented. Despite a drop in malpractice payments seen with that programme, the centre mostly served US military veterans and it was unclear whether the findings could be extended beyond that population. The Michigan experience shows that they might.

CLAIMS AND COSTS BEFORE AND AFTER IMPLEMENTATION



Adapted from *Ann Intern Med* 2010;153:213-21

A total of 1131 claims were recorded during the 12 year study, 633 before the new programme was implemented and 498 after. Average monthly figures per 100 000 patients decreased in the second period for new claims (from 7.03 to 4.52) and lawsuits (2.13 to 0.75). Median time to resolution decreased from 1.36 years to just under a year, and the average cost per lawsuit decreased from $405 921 (£261 454; €319 825) before implementation to $228 308 after.

The findings might in part be the result of a change in state legislation aimed at controlling malpractice, which was introduced seven years before the study began.

Ann Intern Med 2010;153:213-21

What works and what doesn't work for rotator cuff tears?

Despite analysing data from 137 controlled and uncontrolled studies, a systematic review failed to identify the best method for treating tears of the rotator cuff. All of the 21 randomised trials were judged to have high risk of bias, and the quality of other studies was moderate on average. The review included surgical and non-surgical approaches.

Return to work was earlier for "mini open repair" versus open repair and for continuous passive motion with physical therapy versus physical therapy alone. Functional improvement was greater with open repairs than with arthroscopic debridement, but no differences were found between open repair and mini open repair, mini open repair and arthroscopic repair, arthroscopic repair with acromioplasty and arthroscopic repair without acromioplasty, or single row fixation and double row fixation.

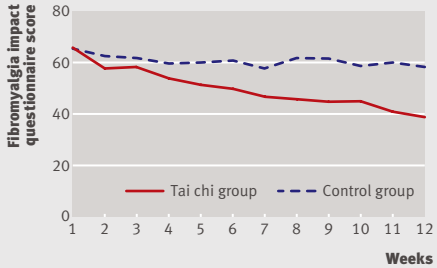
Rates of complications were low across all studied interventions.

Ann Intern Med 2010;153:246-55

Tai chi is better for fibromyalgia than education plus stretching

Tai chi is a mind-body practice that originated in China as a martial art and has been described as a complex, multicomponent intervention that integrates physical, psychosocial, emotional, spiritual, and behavioural elements. In a trial of 66 people with fibromyalgia, tai chi was delivered in two hour long weekly sessions over 12 weeks by a master with more than 20 years of teaching experience.

QUESTIONNAIRE SCORES ACCORDING TO TREATMENT GROUP



Adapted from *N Engl J Med* 2010;363:743-54

The control intervention was delivered over the same time scale, with each session consisting of 40 minutes of education by health professionals on various topics related to fibromyalgia, followed by 20 minutes of stretching. All participants were advised to exercise at home for at least 20 minutes each day.

On the fibromyalgia impact questionnaire, where scores range from 1 to 100, with higher scores indicating worse symptoms, mean scores at baseline and 12 weeks in the tai chi group were 62.9 (SD 15.5) and 35.1 (18.8), respectively, compared with 68.0 (11) and 58.6 (17.6) for the control group. Tai chi also topped education and stretching for general physical and mental wellbeing (measured by short form 36 questionnaire), mood, quality of life, sleep, self efficacy, and capacity for exercise. Results favouring tai chi persisted to 24 weeks.

Current treatment options for fibromyalgia include exercise, sleep hygiene, cognitive behavioural therapy, and various drugs, none of which helps patients enough, says an editorial (p 783). The current trial raises questions of placebo effect and appropriate trial comparisons for tai chi. But doctors now at least have evidence on which to base support for patients' possible interest in tai chi, which also holds promise for rheumatoid arthritis, osteoarthritis, and low back pain.

N Engl J Med 2010;363:743-54

Steroids given before organ harvesting don't prevent acute renal failure in kidney recipients

Many recipients of kidneys harvested from dead donors develop acute renal failure after transplantation. A randomised trial done in three centres in Austria and Hungary tested a strategy to reduce this.

"No wonder the youth of today are going deaf . . . The twitter of birds and the crackling of a fire, the chanting of a shaman and the occasional bellow of an auroch or growl of a sabre toothed tiger—that's all we can really cope with"

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

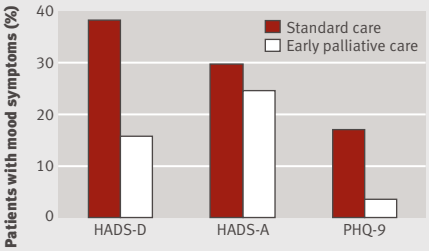
Donors, who were brain dead but with a pumping heart, received intravenous infusions of methylprednisolone (136 donors) or placebo (saline; 133 donors) at least three hours before organ harvesting. Most donors and recipients were white. Although suppression of immune response and inflammation was confirmed in kidney biopsies of donors who were given steroids, the outcomes did not differ between patients who received kidneys from donors treated with steroids and those who received kidneys from controls.

Acute kidney failure developed in 22% of recipients (52/238) in the steroids group compared with 25% (54/217) in the control group. One graft was lost in the first day after transplantation in each group. Median duration of acute kidney failure was five days in the steroid group and four days in the placebo group (P=0.31). Trajectories of serum creatinine concentration in the first week were also similar in the two groups.

Ann Intern Med 2010;153:222-30

Early palliative care can improve outcomes for people with severe illness

EFFECT OF EARLY PALLIATIVE CARE ON MOOD AT 12 WEEKS



Adapted from *N Engl J Med* 2010;363:733-42

Should palliative care start only after life prolonging or curative care is no longer appropriate? A non-blinded trial tested the effect of adding palliative care to standard treatment for cancer as soon as the diagnosis is made. Participants were 151 people with metastatic non-small cell lung cancer.

People who received early palliative care had better quality of life 12 months into the trial on all three quality of life measures used. Early palliative care also resulted in better mood, as measured by two subscales of the hospital anxiety and depression scale—HADS-A, which measures symptoms of anxiety, and HADS-D, which measures symptoms of depression—as well as the patient health questionnaire 9 (PHQ-9), which evaluates symptoms of major depressive disorder.

People who received early palliative care had less aggressive care, which was defined as chemotherapy in the last two weeks of life, no hospice care, or admission to a hospice three days or less before death (33% (16/49) *v* 54% (30/56) in the control group). Even so, survival was longer with early palliative care than with standard care (median 11.6 *v* 8.9 months). Finally, documenting resuscitation preferences was more common in the palliative care group (53% (18/34) *v* 28% (11/39) in the standard care group).

Improved survival with palliative care may result from control of depression, improved management of symptoms, or a reduction in the need for hospital admission, say the editorialists (p 781). But whether better outcomes are the result of palliative care itself or additional attention from doctors and other healthcare workers is not clear.

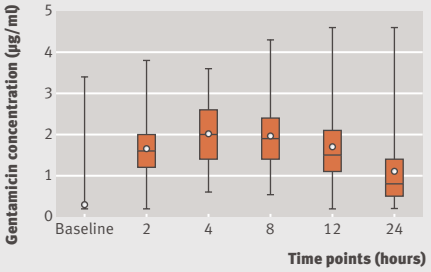
N Engl J Med 2010;363:733-42

Antibiotic sponges may not prevent infection after heart surgery in high risk patients

Gentamicin-collagen sponges have been shown to halve surgical site infections in trials in Europe, but this was not the case in a trial of people with diabetes or obesity, or both, who were undergoing heart surgery in the US. All participants received systemic antibiotics and rigid fixation of the sternum. The trial was done in 48 hospitals, not just the one or two in previous trials. Onsite monitoring and source data verification were carried out, as well as central adjudication of outcomes by an independent blinded committee, all of which were absent in previous trials.

The 1502 participants, of whom two thirds had diabetes and three quarters were obese, had similar outcomes irrespective of group assignment. The sponge versus no sponge comparison found sternal wound infections in 8.4% (63/753) *v* 8.7%(65/749) of participants, respectively, as well as no differences in superficial wound infections (6.5% (49/753) *v* 6.1% (46/749)), deep sternal wound infections (1.9% (14/753) *v* 2.5% (19/749)), or readmission to hospital for sternal wound infection (3.1% (23/753) *v* 3.2% (24/749)). The ASEPSIS score, which takes into account things like presence of serious or purulent discharge, separation of deep tissues, isolation of bacteria, and mean length of stay in hospital was 1.9 (SD 6.4) *v* 2.0 (7.2).

SPONGE INSERTION AND GENTAMICIN CONCENTRATIONS



Adapted from *JAMA* 2010;304:755-62

In discussing possible explanations for the marked difference in results compared with previous trials, the authors speculate that gentamicin may be lost from the body too quickly to add efficacy to systemic antibiotics. This study could not confirm or refute this, however, because serum concentrations of gentamicin were measured in only a small subgroup of participants. Variation in the distribution of the pathogens could also account for the discrepancy: 6.3% of US patients had meticillin resistant *Staphylococcus aureus* in the infected wound compared with none of the patients in the previous largest trial.

JAMA 2010;304:755-62

Health of living kidney donors may vary with ethnicity

We know of disparities in the burden of diabetes, hypertension, and chronic kidney disease between different ethnic groups, but does this also apply to people who donate kidneys? A retrospective study used insurance data from one private insurer in the US. Of 4650 donors, three quarters were white, 13% were black, and 8% were Hispanic.

Compared with white people, black people had an increased risk of high blood pressure (hazard ratio 1.52, 95% CI 1.23 to 1.88), diabetes that requires treatment with drugs (2.31, 1.33 to 3.98), and chronic kidney disease (2.32, 1.48 to 3.62). No excess risk was seen for cardiovascular disease. Similar results were seen for Hispanic people.

When extrapolating from the general population, only the prevalence of hypertension in some subgroups was higher than expected. End stage kidney disease occurred in fewer than 1% of kidney donors but was more common in black people than in white people.

N Engl J Med 2010;363:724-32

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