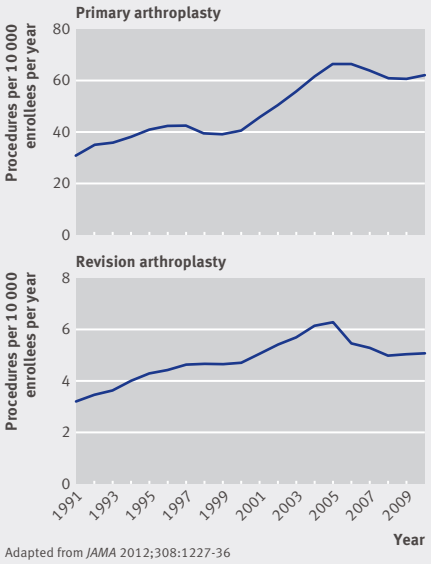
All you need to read in the other general medical journals
Alison Tonks, associate editor, *BMJ* atonks@bmj.com

"Come on, university departments of primary care: drop what you're doing and let's have a programme of coordinated comparative effectiveness research which can deliver the information that clinicians really need for shared decision making with patients"
Richard Lehman's blog at www.bmj.com/blogs

Demand for knee replacement surgery rises steadily in the US

Knee replacement procedures 1991 to 2010



Adapted from *JAMA* 2012;308:1227-36

The number of total knee replacements done each year in the US increased by 161.5% from 1991 to 2010, say researchers. An ageing population is partly to blame, although obesity and expanding indications for surgery may also have contributed. Rates of primary knee replacement operations per capita doubled (from 31.2/10 000 to 62.1/10 000), and rates of revision operations went up by 59.4% during the same period (from 3.2/10 000 to 5.1/10 000).

The trends emerged from administrative data kept by Medicare, federally funded healthcare for adults aged 65 years or more. Other notable findings include a significant drop in length of stay (from eight days to 3.5 days for primary procedures; P<0.001), which was accompanied by a significant rise in readmissions to hospital within a month of discharge (from 4.2% to 5%; P<0.001). Being older, sicker, and male were all associated with a higher risk of readmission in adjusted analyses.

Postoperative mortality hasn't changed much since 1990, although the researchers noticed a worrying increase in wound infections after a revision arthroplasty (from 1.4% (95% CI 1.3% to 1.5%) to 3.0% (2.9% to 3.1%); P<0.001).

By 2010, Medicare was paying for just over 250 000 primary and revision procedures each year. Overall demand is projected to reach 3.5 million procedures a year by 2030, says a linked editorial (p 1266). Knee replacement surgery is cost effective, but with such high numbers, containing costs (while maintaining quality of care) has to be a government priority. Options already being considered include restructuring reimbursements, controlling the use of new expensive implants, and establishing joint replacement registers to help compare the multitude of implants now available.

JAMA 2012;308:1227-36

Cite this as: *BMJ* 2012;345:e6597

Fewer road crashes in the year after a medical warning

In 2006 the government of Ontario, Canada, introduced financial incentives to encourage doctors to warn patients who may be unfit to drive. Medical warnings have been recorded ever since, allowing researchers to track road crashes in all 100 075 adults from the state who were issued with a warning between 2006 and 2009. In the three baseline years before a medical warning, the rate of crashes serious enough to require a visit to the emergency department was 4.76 per 1000 people per year. The rate fell to 2.73 per 1000 people per year in the year after a warning. The difference was significant and consistent across all age groups; both sexes; and for patients with diverse diagnoses including alcoholism, dementia, dizzy spells, and stroke. Even after a warning, the overall rate of crashes in this cohort remained higher than in the general population of Ontario.

Does an official warning from a doctor prevent road crashes that result in injury? Possibly, say the authors. The rate of crashes in which the patient was a passenger or a pedestrian did not change after a warning.

Doctors in Ontario are paid $C36.3 (£22.8; €28.6; $37) each time they warn a patient who may be unfit to drive. Between 10% and 30% of patients lose their licence as a result. In this cohort, warnings were associated with a significant increase in emergency department visits for depression. Patients also made fewer visits to their doctor in the year after a warning, which may signal problems with doctor-patient relationships, say the authors.

N Engl J Med 2012;367:1228-36

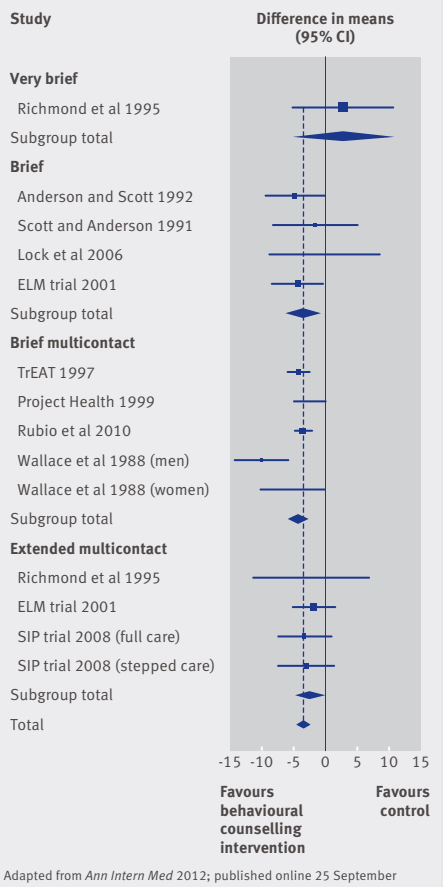
Cite this as: *BMJ* 2012;345:e6596

Brief counselling reduces hazardous drinking

Brief counselling, repeated at least once, could be the best way to help adults cut down their hazardous drinking, according to a meta-analysis of 23 randomised trials. A single episode of behavioural counselling also worked, but not as well. Together, behavioural counselling by primary care providers reduced adults' drinking by an average 3.6 drinks a week over 12 months (95% CI 2.4 to 4.8 drinks a week), reduced the proportion of adults reporting binges, and increased the proportion of adults sticking within recommended limits. All the changes were significant relative to controls, who generally had contact with health professionals but no counselling.

Brief counselling usually lasted about 15 minutes and could include advice, education, cognitive therapy techniques, feedback, drinking diaries, and self help exercises to do at home.

Change in drinks per week over one year



Adapted from *Ann Intern Med* 2012; published online 25 September

All participants in the review had been identified as problem drinkers through screening in primary care. Most had risky or hazardous levels of drinking, not dependence or misuse. Behavioural counselling helped control their drinking for 12 months, but the authors couldn't tell whether changes in behaviour meant fewer injuries, admissions to hospital, a lower risk of liver damage, or a longer life. Other important gaps in the evidence included how best to help pregnant women with drinking problems and adults with comorbid anxiety, depression, or chronic pain.

Ann Intern Med 2012; published online 25 September

Cite this as: *BMJ* 2012;345:e6599

Hazards of poor renal function are independent of diabetes and hypertension

Poor renal function is a risk factor for death, cardiovascular death, and end stage renal disease. Risks rise as estimated glomerular filtration rates fall. They rise faster in adults with proteinuria.

These hazards are about the same for people with and without diabetes, according to a new meta-analysis. Although people with diabetes had higher absolute mortality than people without, the relative hazards associated with a low glomerular filtration rate or proteinuria were about the same in both patient groups. Renal disease is an important risk factor, whether or not you have diabetes, say the authors.

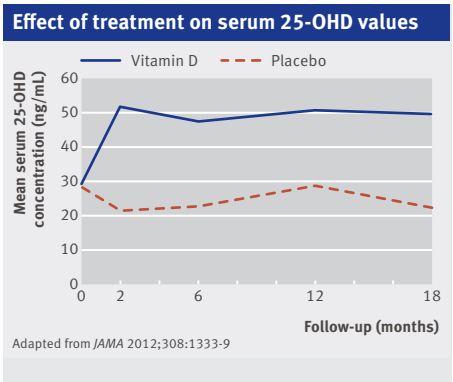
A second meta-analysis did a similar investigation that compared adults with and without hypertension. If anything, the hazards of poor renal function looked worse for adults with normal blood pressure. Low glomerular filtration rate and proteinuria were more strongly associated with death in adults without hypertension than in adults with hypertension. The association between low glomerular filtration rate or proteinuria and end stage renal disease looked about the same in both groups.

Both studies analysed data from more than 40 observational cohorts and more than one million people. The results tell us that simple measures of kidney health are good predictors of important outcomes regardless of the presence of hypertension or diabetes, says a linked comment (doi:10.1016/S0140-6736(12)61300-2). They confirm that even moderate impairment of kidney function is a risk factor for death from cardiovascular disease in otherwise healthy people. These studies can't yet tell us precisely who we should screen with these simple measures or how best to manage those we identify as abnormal.

Lancet 2012;doi:10.1016/S0140-6736(12)61350-6, 61272-0

Cite this as: *BMJ* 2012;345:e6602

Not curing the common cold



Adapted from *JAMA* 2012;308:1333-9

A large dose of oral vitamin D every month did not prevent a single upper respiratory tract infection in the latest trial to test supplements against a placebo. Healthy adults from Christchurch in New Zealand took 100 000 IU a month for 18 months. They reported the same number of coughs and colds as controls (3.7 *v* 3.8 per person; risk ratio 0.97, 95% CI 0.85 to 1.11). Their upper respiratory symptoms were just as severe and lasted just as long as symptoms reported by controls, despite significantly higher serum concentrations of 25-hydroxyvitamin D (25-OHD). The supplements did not reduce sickness absence from work or the proportion of throat swabs containing pathogenic viruses.

This was a rigorous trial, big enough to report a trustworthy negative result, says a linked editorial (p 1375). There is no evidence here, or anywhere else, that vitamin D supplements help healthy adults avoid viral coughs, colds, or sore throats. The 322 participants were not deficient, but neither are the many thousands of people who look to vitamin D supplements for protection every winter. This trial ran through two winter seasons.

Vitamin D protects bone health but does not prevent or cure the common cold, says the editorial. It's a pity, but we should believe it. Vitamin D can be added to the long list of other ineffective prophylactics and remedies that includes vitamin C, echinacea, garlic, intranasal corticosteroids, and zinc.

JAMA 2012;308:1333-9

Cite this as: *BMJ* 2012;345:e6610

Patients report benefits from online access to doctors' notes

Three groups of primary care doctors in the US have been experimenting with an online system that invites patients to read notes written by their doctors after a consultation. Just under 20 000 patients and 105 doctors tried it for a year and were surveyed about their experiences. Almost all the patients who responded (41% of the 13 564 who had access to at least one note), said they wanted open notes to continue. Large majorities in all three centres thought the experience had given them more control, greater understanding, and helped them adhere to care plans and drugs. A third of patients were worried about privacy.

Doctors were generally less optimistic than patients about the benefits of open notes and more worried than patients about causing offence, anxiety, or confusion. But their initial fears about increased workload failed to materialise. When asked "what's the best thing about opening your notes to patients online?" free text responses from 73 of 104 doctors mentioned improved relationships, more empowered and satisfied patients, transparency, shared decisions, and opportunities for education. About a fifth said they would prefer not to continue with open notes, but none opted out when given the opportunity.

Even allowing for selection bias, patients who tried open notes certainly seemed to like them, say the authors. Doctors reported few problems, despite initial reservations, and all three groups of practices have decided to broaden patients' access to notes still further.

Ann Intern Med 2012; published online 1 October

Cite this as: *BMJ* 2012;345:e6600

Are we oversubscribing β blockers for heart disease?

β blockers are recommended for heart failure and for secondary prevention after a recent myocardial infarction (MI). Doctors should think twice before prescribing these drugs to other high risk groups, say researchers. Adults with a remote history of MI, those with cardiovascular disease but no history of MI, and those with just cardiovascular risk factors did not seem to benefit from β blockers in a large observational study (n=21 860). Treatment was not associated with a lower risk of cardiovascular death, nonfatal MI, or stroke in fully adjusted analyses, and the authors found no evidence of cardiovascular benefit over four years in any of the three patient groups. They did confirm a lower risk of all cardiovascular events combined in a subgroup of adults with a recent MI.

Current practice is underpinned by old evidence that accumulated before modern reperfusion therapies and cardioprotective drug protocols, say the authors. β blockers may not be as effective for many patients as was previously thought. International guidelines are already being revised.

JAMA 2012;308:1340-9

Cite this as: *BMJ* 2012;345:e6612