Trying to make sense of the Middle East

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Deborah Cohen, the *studentBMJ* editor, spent six days in Israel and the occupied Palestinian territories, talking to both Israelis and Palestinians about health care and the problems facing West Bank inhabitants (p 474). In her diary account, she reports on the use of ambulances for transporting militants, weapons, and explosives, and on movement restrictions, women giving birth at checkpoints, sick people not receiving medical help, breakdown in herd immunity, the escalation of intermarriage, and a rise in domestic violence.

POEM*

Levonorgestrel IUD reduces dysfunctional bleeding

Question Does levonorgestrel intrauterine system (Mirena) reduce dysfunctional uterine bleeding as well as endometrial resection?

Synopsis Many women with heavy menstrual bleeding might prefer a less invasive treatment than endometrial resection or hysterectomy. The levonorgestrel intrauterine system induces atrophy of the endometrium for more than five years. In this Finnish study, 59 women aged 30 to 49 referred for treatment of menorrhagia were randomised to transcervical endometrial resection or insertion of the levonorgestrel device and followed up for three years. The principal outcome was menstrual bleeding, and the study was large enough to detect a difference of about 15 ml of blood loss per menstrual period, as estimated by a diary description. Mean estimated blood loss after treatment did not differ between groups. Haemoglobin and ferritin levels increased similarly in both groups. Treatment success was defined as an estimated blood loss of less than 60 ml, which was not achieved in three women with the device and two women in the resection group. During follow up, 11 of 30 women with the device dropped out: most because of pain, only one due to menometrorrhagia. In the resection group, seven of 29 women dropped out, mostly for bleeding or pain, and that group included four women who had repeat resection and two who had a hysterectomy.

Bottom line Some gynaecologists in the United States use the levonorgestrel intrauterine system (Mirena) to treat women with menorrhagia and no underlying disease. This small study showed equivalent results to endometrial resection for reducing menstrual blood loss with a three year follow up. Larger studies are needed to evaluate its safety and tolerability.

Level of evidence 2b (see www.infopoems.com/levels.html). Individual cohort study or low quality randomised controlled trial <80% follow up.

Rauramo I, Elo I, Istre O. Long-term treatment of menorrhagia with levonorgestrel intrauterine system versus endometrial resection. *Obstet Gynecol* 2004;104:1314-21.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

Affairs of the thorax

The *BMJ* strives to help doctors in their clinical practice. An important difference between the *BMJ* and the *Lancet*, as one *Lancet* editor described it, is that the *BMJ* publishes articles focusing on the point of delivery in health care, where doctor meets patient and policy maker meets policy. Some, possibly too many, readers believe that our vision has drifted woefully from the point of delivery to an obsession with health policy and the "softer" social and political issues that are mere eyewash to dedicated clinicians (pp 474, 478). Our view is that a good journal incorporates all these elements and that diversity is the strength of the *BMJ*. Even so, we spend a great deal of time trying to find ways to publish more papers of clinical relevance,

This week we cut through the soft underbelly of social medicine to report findings that should interest our readers who spend their days marching around hospital wards and locked in patient consultations. Any doctor with a day's clinical experience will have faced the challenge of narrowing down the possible causes of chest pain. We've all been through it, straining to elicit textbook descriptions of angina or pleuritic chest pain, followed by a prod of the patient's chest, searching for the reassurance of a less life threatening diagnosis. In the heat of an examination the usefulness of a diagnostic test is less bothersome than the thought of awkward questions on the morning ward round and the vision of the lead physician rubbishing your diagnosis of pulmonary embolism with the patient's cry of aguish as he reproduces the chest pain by palpation. Well, forget all that. Gregoire Le Gal and fellow investigators studied the records of 965 people with suspected pulmonary embolism to discover that reproducing chest pain by prodding and pummelling a patient's chest is not associated with a lower prevalence of pulmonary embolism (p 452).

Doctors from New Zealand reveal another useful message for clinicians treating people with non-severe community acquired pneumonia. They investigate the effectiveness of β lactams compared with antibiotics with specific activity against atypical pathogens and find that β lactams should be the antibiotics of choice in all patients except the few with legonella related pneumonia (p 456). In an accompanying commentary, Mark Woodhead and Theo Verheij describe this meta-analysis as a valuable contribution to a topic that causes fierce discussion among doctors (p 460).

Continuing with affairs of the thorax, a multinational observational study addresses the dilemma of where to send patients with acute coronary syndrome. Should they be dispatched to the nearest cardiac catheterisation laboratory? Will the nearest hospital do even if it does not have interventional facilities? Frans Van de Werk and others discover that availability of a catheterisation laboratory does not confer survival benefit and may even increase the risk of major bleeding and stroke in hospital (p 441). That's as relevant to the point of delivery as you can get.

Kamran Abbasi *acting editor* (kabbasi@bmj.com)

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