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This week in the BMJ

Early use of oral antibiotics in severe community acquired pneumonia is safe

ZEPHYR/SPL

Switching intravenous antibiotics to the oral route after three days in patients with severe community acquired pneumonia shortens hospital stay and seems to be safe. Oosterheert and colleagues (p 1193) randomised 302 patients with pneumonia, who were not in intensive care, to receive three days of intravenous and seven days of oral antibiotics or 10 days of intravenous antibiotics. Mortality rates and clinical cure rates were similar in the two groups, but patients in the oral treatment group were discharged earlier.

Occupational therapy improves function in dementia

WILL & DENI MCINTYRE/SPL

Community based occupational therapy for elderly patients with dementia improves daily function and reduces the burden on carers say Graff and colleagues (p 1196). One hundred and thirty five people over 65 with mild to moderate dementia were randomised to receive 10 sessions of occupational therapy, including cognitive and behavioural interventions, over five weeks or no additional treatment. The positive effect of treatment remained significant seven weeks after the intervention ended despite patients' limited learning abilities. The number needed to treat for a clinical improvement was 1.3.

Should babies be left to sleep in infant car safety seats?

EDWARD HATTERSLEY/ALAMY

Young infants should not be left unattended to sleep in standard car safety seats as they may be at risk of hypoxia say Tonkin and colleagues (p 1205). They examined 43 consecutive infants presenting after an acute life threatening event and found that nine had been asleep in such seats at the time of a perceived change in colour and breathing. All infants seemed otherwise healthy. Car seats may cause forward flexion of the neck and lead to impaired airway function and oxygen desaturation.

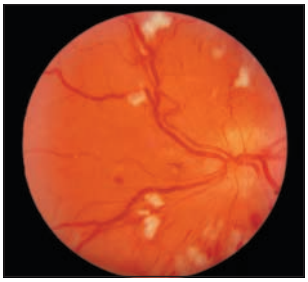
Tube feeding in advanced dementia can be harmful

Tube feeding patients with advanced dementia does not prolong life or improve its quality and can actually shorten the life of some patients. In an analysis and

AUX/PHANIE/REX

comment article, Hoffer (p 1214) reminds us that elderly patients who eat very little are usually not starving but have low energy requirements and exist in a state of metabolic homoeostasis. Good practice comprises regularly weighing patients to be sure that weight loss is not life threatening and paying attention to the quality, characteristics, and presentation of their food.

How to achieve strict glycaemic control in type 2 diabetes



PAUL PARKER/SPL

Effective treatment of hyperglycaemia and strict glycaemic control are key to reducing microvascular complications in patients with type 2 diabetes. In a clinical review (p 1200), Heine and colleagues say that achieving this goal usually involves complex treatment with combinations of glucose lowering agents. Because the natural course of type 2 diabetes is characterised by a gradual decline in β cell function, the usual stepped approach to management often results in recurrent hyperglycaemia. The authors discuss effective interventions that reduce treatment failure and improve long term outcomes.

bmjupdates+

SSRIs start to relieve depression soon after the start of treatment

Research question Do selective serotonin reuptake inhibitors take weeks to work?

Answer Probably not. Symptoms of depression improve during the first week of treatment

Why did the authors do the study? Patients with depression are often told to expect a delay of several weeks before their antidepressant starts to work. But the research on this issue is inconsistent. These authors wanted to find out if the rapid response reported by some trials of selective serotonin reuptake inhibitors (SSRIs) is real or just a placebo effect.

What did they do? They searched systematically through seven established research databases for published trials in any language that compared an SSRI with placebo in patients with depression. Their search included reference lists, conference proceedings, and abstracts. They included 50 trials in the final review and meta-analysis. The trials included 6153 patients treated with any SSRI licensed in the UK and 3968 controls treated with a placebo. Most of the patients were treated in primary care or psychiatric outpatient settings. They were at least moderately severely depressed at baseline.

The authors pooled data on depression rating scales for each of the first six weeks of treatment. They then matched their analysis against five models describing different patterns of response to treatment, including an early or a late start. They did further analyses of groups of trials reporting changes in scores from baseline or predefined response rates.

What did they find? In the primary analysis of 28 trials, the pooled data best fit a model describing an early response to treatment. In this model, patients' symptoms improved most during the first week of treatment and continued to improve, but more slowly, for the next six. In the secondary analyses, patients treated with an SSRI had significantly lower symptom scores (from the Hamilton or Montgomery-Asberg depression rating scales) than patients treated with placebo by the end of the first week. The difference increased with time, reaching −3.3 (95% CI −4.14 to −2.45) on the Hamilton scale by the end of six weeks. There was also a significant increase in the chance of a "response" during the first week for patients treated with an SSRI (relative risk 1.64 (1.2 to 2.25), number needed to treat = 25). Response was usually defined as a 50% improvement in the Hamilton depression scores.

What does it mean? These analyses suggest that SSRI antidepressants work faster than previously thought. These authors found no evidence of a delay between the start of treatment and an effect, and their findings mean that patients can probably expect to feel at least a little better within a week or so. The full treatment effect, or remission, takes several weeks longer, but the authors estimate that patients in these trials had about a third of their eventual response to treatment during the first week. Since most were outpatients, the findings may not apply to patients with severe depression being treated in hospital.

Taylor et al. Early onset of selective serotonin reuptake inhibitor antidepressant action: systematic review and meta-analysis. *Archives of General Psychiatry* 2006;63:1217-23

Editor's choice

New ideas please

Did you know that diabetes kills 3.8 million people worldwide each year, around the same number as HIV/AIDS (p 1191)? Good glycaemic control should lower the risk of cardiovascular disease in diabetes, but it's hard to achieve. R J Heine and colleagues, in their guidelines on hyperglycaemia in type 2 diabetes, unpick the tangle of treatment options (p 1200). The authors, who are based in the Netherlands, Cameroon, and Boston, say their proposed management algorithms will help doctors even where resources are poor. But treatments to alter the relentless decline of β cell function and the clinical course of diabetes are still a long way off. Lifestyle change remains, for now, the potentially most effective and most difficult intervention, and we need better evidence and new ideas to make it happen.

In their ABC article on childhood obesity John J Reilly and David Wilson also report a dearth of robust evidence for lifestyle interventions (p 1207). But they do cite one sound randomised controlled trial in 11 year olds at US schools, in which girls' risk of obesity fell and those who were already obese lost weight, mainly through watching less television. It's hardly a new idea, but a feasible and effective one. The face validity of the intervention may well have helped: for instance, Reilly and Wilson warn that the fears of parents, teachers, and health professionals about encouraging eating disorders might scupper dietary interventions in schools. They, too, say we urgently need new ideas and further research.

Meanwhile, dietitian Carrie H Ruxton calls for fewer platitudes and mantras and more common sense (p 1221). It's all very well to berate multinational food companies, but let's not forget the chip vans parked outside schools, the young people who can't cook, and the low cost home entertainment that keeps too many of us glued to our seats.

Whether home entertainment is low cost is a moot point, particularly among parents looking at their children's Christmas lists. And what about the indirect costs? Minerva reports a woman who broke her fifth metatarsal while using a Sony PlayStation 2 Dance Mat, almost certainly leaving her immobile for more than a month (p 1228). The web is buzzing with debate about whether Nintendo's new Wii games console (whose motion sensitive remote control translates your real golf and tennis strokes into virtual games on the screen) will do more harm through sports injuries than good through getting sedentary people moving. My search for academic articles on this drew a blank, except when "wii and physical activity" pulled up a page from University College London. A red herring, alas: it was a paper from 2003 about physical activity among men with chest disease, from the Whitehall II (WII) study of British civil servants.

I'm not a games console user, but my wish list includes an affordable personal computer that I have to pedal. Again, the web offers plenty of opinions on this, and even the odd prototype. But it seems that I would have to pedal hard, all the time I was working, to generate 200 watts, only about half what a mid-range desk computer uses. Not this Christmas, then.

Trish Groves *deputy editor* (tgroves@bmj.com)