Poor education was associated with mortality in 1990s Russia

GLEB GAVANCHENKO

During the economic breakdown in Russia in the 1990s the greatest increases in

mortality were among men with little education. Plavinski and colleagues (p 1240) used data from two prospective cohorts generated from voting lists in Leningrad (now Saint Petersburg) during the mid-1970s and 1980s. They found that men with university degrees were unaffected by the increased mortality, whereas men with less than high school education were most affected. Low education is a risk for mortality that cannot be fully explained by other risk factors, particularly during times of economic trouble.

POEM*

Azithromycin doesn't prevent recurrent acute coronary syndromes

Question Does azithromycin given to patients with acute coronary syndromes prevent recurrent ischaemia?

Synopsis Previous studies suggest an association between *Chlamydia pneumoniae* and cardiac ischaemia. We have reported at least one trial showing improved survival when a macrolide antibiotic is given to patients with acute myocardial infarction (Gurfinkel, *Lancet* 1997;350:404-7). In this randomised controlled trial (double-blinded), 1439 inpatients with acute coronary syndromes (acute myocardial infarction or unstable angina) were randomly assigned (masked allocation) to receive azithromycin 500 mg orally on the first day followed by 250 mg daily for four days (n=716) or placebo (n=723). The research team evaluated the patients three weeks and six months after the initial event. They used an intention to treat approach and used assessors blind to the initial allocation to assess the study's end points: death or repeat ischaemia. Before the study, the researchers estimated they would need 705 patients in each group to have enough power to detect a meaningful difference in the frequency of these end points. By the end of the study, 23 (3%) patients treated with azithromycin died compared with 29 (4%) of the control patients, and 17 (2%) had non-fatal acute myocardial infarction compared with 23 (3%) of the control patients. Finally, 65 (9%) of the patients treated with azithromycin underwent coronary revascularisation (coronary artery bypass graft or percutaneous transluminal coronary angioplasty) compared with 59 (8%) of the control patients. None of these differences were significant. To adjust for other factors that might influence the end points, the researchers used a Cox proportional hazards model that confirmed that azithromycin had no significant benefit.

Bottom line This well done, adequately powered study found that giving short term azithromycin to patients with acute myocardial infarction or unstable angina does not prevent recurrent coronary events in the subsequent six months.

Level of evidence 1b (see www.infoPOEMs.com/resources/levels.html); individual randomized controlled trials (with narrow confidence interval).

Cercek B, Shah PK, Noc M, et al. Effect of short-term treatment with azithromycin on recurrent ischaemic events in patients with acute coronary syndrome in the azithromycin in acute coronary syndrome (AZACS) trial: a randomised controlled trial. *Lancet* 2003;361:809-13.

©infoPOEMs 1992-2003 www.infoPOEMs.com/informationmastery.cfm

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

Editor's choice

Head lice: boring for doctors, important to patients

Doctors don't become famous through working on head lice. Presidents of royal colleges are never experts on head lice. Nobody dies of head lice. Nobody even gets very sick. Head lice are boring to doctors. But head lice matter a lot to patients and can cause great distress. "I felt lost and hysterical," writes a mother who has head lice, along with her two daughters (p 1258). "My older daughter was humiliated by the way the school nurse treated her ... My paediatrician (who I really like) had no suggestions."

A cluster of short pieces beginning on p 1256 considers what we know and don't know about head lice. They come from Best Treatments, a website for patients and healthcare workers based on *Clinical Evidence* that the BMJ Publishing Group has developed together with United Healthcare. The material on head lice is available on bmj.com, but most of the site—which will cover some 60 conditions by the end of the year—is available only to members of United Healthcare plans in the United States. We hope to find ways to make it available in other countries, including Britain.

Most of the conditions covered by Best Treatments are the chronic conditions like heart failure and depression that are the major causes of mortality and morbidity. But we try to respond to signals from patients on conditions that matter greatly to them. Hence head lice.

One problem with head lice is that many people think their children have them when they don't. Reliably identifying live lice is not easy, and, writes Ian Burgess, "nobody can reliably identify viable eggs, even with the aid of a microscope, unless the young louse can be seen moving inside the shell." This is one of the reasons why school "no-nits" policies (banning children with nits (hatched egg shells) until all nits are removed) don't make sense. Further, less than a fifth of school children with nits go on to develop infestation within 14 days, and infection is spread only by prolonged head to head contact.

Initial treatment often fails. "Bug busting" (wet combing with conditioner) works in only about a third of people and is often uncomfortable for children. Over the counter remedies fail because not enough of the product is used or because it isn't repeated after 7-10 days. Treatment also "fails" because patients weren't infected in the first place. An increasingly common reason for failure is insecticide resistance. If a patient has adequately applied over the counter products but still has lice, the most reliable prescription is malathion (despite resistance being reported in Britain and France). But it's smelly and hard to apply.

It's easy to see why doctors are irritated by head lice and patients very bothered by them. Next week's issue of the *BMJ* will be different from normal and will try to look forward to a world where doctors and patients work much more in partnership than they do now.

Richard Smith *editor*

To receive Editor's choice by email each week subscribe via our website: bmj.com/cgi/customalert