Corticosteroid injection improves knee pain

Intra-articular corticosteroid injections improve symptoms of osteoarthritis of the knee in the short term, and may work even after six months. Arrol and Goodyear-Smith (p 869) reviewed 10 randomised trials and found that intra-articular steroid injections improved

symptoms at one to two weeks (relative risk 1.66). Only one study of good quality had results at 16-24 weeks; it showed a benefit from treatment. No major harms were found, and the only study investigating potential loss of joint space found no harm after steroid injection. Higher doses of corticosteroids may be needed to obtain long term benefits, the authors say.

POEM*

Low dose aspirin safely reduced thrombosis in polycythaemia vera

Question Is low dose aspirin safe and effective for the prevention of thrombotic complications in patients with polycythaemia vera?

Synopsis Polycythaemia vera is associated with increased blood viscosity, which in turn leads to thrombotic complications. A previous study with high dose aspirin (900 mg/day) was unsuccessful because of a high risk of gastrointestinal bleeding. In this randomised controlled (double blinded) study, 518 patients with polycythaemia, no contraindication to aspirin, and no other indication for antithrombotic therapy were randomised (allocation concealed) to aspirin 100 mg/day or matching placebo. The average red cell count was 5.9 million cells per microlitre, and most patients had a normal platelet count (range 179 000 to 63 000 cells/mm³). The two primary end points were the combination of nonfatal myocardial infarction (MI), nonfatal stroke, or death from cardiovascular causes, and this combination plus pulmonary embolism (PE) and major venous thrombosis. The groups were balanced at the beginning of the study, analysis was by intention to treat, and patients were followed up for a mean of three years. The study was stopped earlier than intended because of difficulty recruiting patients and lack of funding. Patients were evaluated once a year, and end points were adjudicated by two or more evaluators blinded to the treatment assignment. There was a consistent but not always statistically significant benefit to treatment. The risk of the first (2% v 4.9%; P = 0.09) and second (3.2% v 7.9%; P = 0.03) composite end points was lower in the aspirin group. Thus, you would have to treat 21 patients to avoid one non-fatal myocardial infarction, non-fatal stroke, death from cardiovascular causes, pulmonary embolism, or major venous thrombosis. There were trends toward lower all cause mortality and for each of the individual clinical end points. The risk of major bleeding was similar, with three episodes in the aspirin group and two in the placebo group, but there was a trend toward more minor bleeding in the aspirin group (20 v 12 episodes; P = 0.1).

Bottom line Low dose aspirin (100 mg/day) is safe and reduces the risk of thrombotic complications in patients with polycythaemia vera who have a normal platelet count.

Level of evidence 1b (see www.infoPOEMs.com/levels.html). Individual randomised controlled trials (with narrow confidence interval).

Landolfi R, Marchioli R, Kutti, et al. Efficacy and safety of low-dose aspirin in polycythemia vera. *N Engl J Med* 2004;350:114-24.

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

Editor's choice

The teaching of communication skills may be misguided

Each day in Britain there are some two million consultations between doctors and patients and around 100 million decisions about patient care. Any fundamental reform of health care will depend on influencing those consultations and decisions, and they are, I suggest, so far largely untouched. "Thank God," I hear many doctors say, but who could disagree that much of what goes on in those consultations is capable of considerable improvement?

One method of improving what happens in consultations is through teaching doctors communication skills, but a paper from Liverpool suggests that the teaching has been driven too much by what doctors think is good communication rather than by what patients want (p 864). The authors studied consultations between 12 doctors and 39 patients with breast cancer and asked patients "to describe aspects of communication they valued or deprecated." The results suggest that some teaching on communication may be misguided.

Patients didn't think about their doctors in terms of how well they communicated. Instead, they cared about whether their doctors had expertise, had a personal relationship with them, and respected their autonomy. Teaching has emphasised shared decision making, but "no patient described a process of decision making." They liked instead being given a recommendation with the option to say no, and "they had concurred with clinicians' recommendations."

The paper offers practical examples of how the doctors communicated expertise, built relationships, and showed respect for the patients. Interestingly, "being a doctor was often sufficient" to convince patients of expertise. In other words, patients start by trusting doctors. Trust doesn't have to be won—but can be lost: "Trust in doctors' expertise was irretrievable if patients thought they had been misled." Doctors could also encourage belief in their expertise by displaying confidence and efficiency, making things happen, and by answering all questions without hesitation.

Non-verbal cues—eye contact, smiling, touching—were important in building a relationship. "The simplest verbal strategy was for the patient to be told she was special." Humour and idiosyncrasies also helped. Patients felt respected when doctors communicated with them at eye level and matched their language to the patients' expectations.

The authors argue that their results can be generalised, but I wonder. Patients with breast cancer may be radically different from patients with conditions that are not life threatening, and it's not clear if patients were offered the choice of sharing decisions. It might be that they were content with what they were offered but could have found more empowerment even more attractive. And—a question that interests me—how do you share the uncertainty that is ubiquitous in medicine and still seem to have expertise?

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