

lifestyle have no effect on the control of blood pressure. Little and colleagues (p 1054) randomised 296 patients with a single high reading to combinations of simple interventions—an information booklet, lifestyle prompts, and advice to use a low sodium-high potassium salt—or standard care. The interventions did not modify blood pressure but they did prompt patients to change their diet, which may be important in the overall management of blood pressure.

## Patients with unexplained symptoms do not push for treatment

Patients with unexplained symptoms do not directly ask

for an intervention, but they may pressurise general practitioners for somatic management in other ways. In a qualitative study of 36 consultations with patients with medically unexplained symptoms, Ring and colleagues (p 1057) found that, even though no patient asked for investigation or medical referral, most patients received interventions (prescriptions, investigations, or referrals). Patients presented their symptoms in a variety of complex and compelling ways, perhaps in the attempt to engage their doctors and convey the reality of their suffering. Doctors might have felt pressured for somatic interventions because they mistook patients' insistence as a desire for intervention or because they lacked another response to evident suffering, say the authors.

### POEM\*

#### Use a single course of steroids for preterm rupture of membranes

**Question** Do weekly courses of corticosteroids given to women with preterm premature rupture of membranes lead to better neonatal outcomes than a single course?

**Synopsis** Weekly courses of corticosteroids are recommended for women at risk for preterm birth with membranes intact (PPROM). This report is a planned secondary analysis of 161 women with PPRM and gestation between 24 and 32 6/7 weeks' gestation enrolled in a randomised controlled trial of single versus weekly courses of corticosteroids. A course of corticosteroid was two doses of 12 mg betamethasone intramuscularly 24 hours apart. All women with PPRM received antibiotics, usually penicillin and a macrolide. There was no difference in the primary outcome of composite neonatal morbidity (defined as any of severe respiratory distress syndrome, bronchopulmonary dysplasia, severe intraventricular haemorrhage, periventricular leukomalacia, necrotising enterocolitis, sepsis proved by culture, and perinatal death). Chorioamnionitis was more frequent in the weekly course group (48% v 32%). There were no differences in the rates of endometritis or neonatal sepsis.

**Bottom line** A single course of antenatal corticosteroids is recommended for women with preterm premature rupture of membranes. Weekly courses do not improve neonatal outcomes and are associated with increased risk of chorioamnionitis.

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

Lee MJ, Davies J, Guinn D, et al. Single versus weekly courses of antenatal corticosteroids in preterm premature rupture of membranes. *Obstet Gynecol* 2004;103:274-81.

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

## Editor's choice

### Insights into intimacy

Two qualitative studies in this week's journal provide insights into intimacy—one into the intimacy of sex, the other into the intimacy of the consultation between a patient and a general practitioner. Both are closed worlds where third parties can never quite know what happens.

John M Tomlinson and David Wright have used semistructured interviews to explore what erectile dysfunction means to men (p 1037). All the men had been treated and much of the originality of the study lies in half of the sample being selected because treatment had failed. Many men are devastated by the condition. Their manliness is taken away. "I associate getting an erection with being a man." "Nobody's going to have any respect for you if you can't get a hard-on." Sexuality was central to their lives.

Some men felt "old before their time" and imagined the condition to be irreversible. They felt that they had failed their partners and worried that they might lose them. "If I can't keep an erection I'm not going to keep a woman." Yet—classically for men—almost half had not been able to discuss the problem with their partners. Most had exaggerated ideas of the power of sildenafil (Viagra). They expected instant erections that might be "uncontrollable," abnormally large, or very long lasting. One man expected to "perform wonderfully." The authors blame the media for excessive expectations, but I wonder about the influence of Pfizer, the manufacturers of the drug and the funders of the study, the power of pub talk, and the male capacity for fantasy.

Some were highly gratified by the treatment: "I could have thrown open the window, shouted 'Eureka'...and beat my chest like an apeman." Disappointment was extreme in those for whom the treatment didn't work: "I could tell you how empty I feel... it's almost like a bereavement."

The study by Adele Ring and others looks at the complex interactions between general practitioners and patients with medically unexplained symptoms (p 1057). Such patients make up a fifth of those seen by general practitioners and are often termed "heartsink." These patients commonly receive ineffective and potentially harmful investigations and treatments, and conventional medical wisdom has it that the doctors (who come almost to be seen as the victims) are pressurised by the patients.

Yet none of the 36 patients asked for investigation or medical referral, although 10 asked for other interventions. Why then do doctors habitually treat the patients symptomatically? The authors believe that the patients try to engage the doctors, but when they respond with simple explanations and threaten to end the engagement the patients try harder to transmit the intensity and complexity of their symptoms. The doctors then offer treatment either because they mistake the patients' attempts at engagement for insistence on treatment or because they've run out of explanations. Either way, it's poor medicine.

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