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Joint replacement, thromboprophylaxis, and orthopaedic surgeons

The benefits of joint replacement surgery are often compromised by thromboembolic complications, and the optimal approach to prophylaxis is uncertain. Two papers in this week's journal throw light on the issue.

Laverick *et al* surveyed the use of prophylactic regimens by orthopaedic surgeons in the United Kingdom, and on p 549 they discuss the variability and lack of consensus among their respondents. Most orthopaedic surgeons are using prophylactic drugs for joint replacement, but many of the regimens are of unproved benefit. They conclude that better—not simply more—information is needed on the efficacy of prophylaxis.

The most effective treatment so far has been unfractionated subcutaneous heparin in doses adjusted according to the partial thromboplastin time. On p 543 Leyvraz *et al* report the results of a European multicentre trial comparing this labour intensive method of prophylaxis with one daily dose of a low molecular weight heparin (Fraxiparine) in patients undergoing hip replacement. The low molecular weight heparin was at least as effective as unfractionated heparin in preventing deep vein thrombosis (22/174 (13%) patients *v* 28/175 (16%) patients developed deep vein thrombosis) and more effective at protecting the proximal veins alone (2·9% *v* 13·1% developed thrombosis of the proximal veins). Bleeding complications and other complications were comparable in the two groups.

Screening for Down's syndrome by individual risk

Determination of fetal karyotypes is mostly carried out because of advanced maternal age, although less than a third of pregnancies associated with Down's syndrome occur in women aged over 35. It has been suggested that modifying age related risk according to concentrations of α fetoprotein and chorionic gonadotrophin would make better use of resources for screening. Lewis *et al* have conducted a retrospective study to test this hypothesis (p 551). They found that screening based on individual risk would have increased the detection rate from 18% to 73% with only a small increase in the number of determinations performed. Adoption of this policy would require that women over 35 lose their automatic right to screening, although the data suggest that those with affected pregnancies would still be detected.

Alcohol consumption and risk of death

Several studies have found that light or moderate drinkers have a lower risk of heart disease than people who do not drink at all. These studies, however, have tended to treat non-drinkers as a homogeneous group, ignoring the possibility that some may be former drinkers. To examine whether all non-drinkers have a higher mortality from all causes and from ischaemic heart disease Lazarus *et al* (p 553) ascertained the mortality in 4070 people whose drinking status was recorded on two occasions, nine years apart. Risk of death during 1974-84 was calculated according to drinking status in 1965 and 1974. Women, but not men, who did not drink had significantly different risks of death depending on whether they had ever drank. Those who gave up drinking between 1965 and 1974 had a significantly greater risk of death from all causes and from ischaemic heart disease than those who continued to drink (relative risks 1·72 and 2·75 respectively) while those who had long abstained had no increased risks. For men, long term abstainers tended to have higher risks than drinkers. These findings suggest that the subgroups within the non-drinking group should be considered when comparing non-drinkers with drinkers.

On p 565 Marmot and Brunner review the evidence for a protective effect of moderate drinking against coronary heart disease. They conclude that despite the flaws in some of the studies the consistency of the findings is convincing, and they propose possible mechanisms for the effect. By putting the apparent advantages of moderate drinking into the context of the enormous health and social problems caused by alcohol, they argue that it would, however, be unwise to recommend that the public drinks alcohol to prevent coronary disease.

Withholding antibiotics for acute red ear

Management of acute red ear in children has been much debated, and it is sometimes recommended that antibiotics be withheld in the first instance. Burke *et al* examined the efficacy and safety of this approach in a double blind placebo controlled trial in general practice of 232 children aged 3-10 years randomised to receive either amoxycillin or matching placebo (p 558). Their findings showed that failure of treatment (non-resolution or recurrence of symptoms requiring the use of a second line antibiotic during the first week) was eight times more likely in the placebo group. More children receiving placebo experienced fever; they also consumed more analgesic, cried for longer, and missed more days from school. There was no significant difference in recorded pain; tympanometry; rate of recurrence of symptoms; or ear, nose, and throat referral in the year of follow up. The authors concluded that use of antibiotics is still an appropriate policy in the acute red ear in children because of the appreciable improvement in short term outcome.

Throwing Light on NHS reforms

On p 568 Professor Donald Light reviews the health service reforms in Britain from the standpoint of 10 years' experience of purchaser and provider markets in the US. He questions the wisdom of restructuring the NHS and unravels some of the complexities of the likely consequences of the government's attitudes to the health service, its introduction of powerful market forces, and a future imbalance between health care in the public and private sectors.