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Dexamethasone and antiemetic treatment after chemotherapy

Ondansetron is the drug of choice for prophylaxis of nausea and vomiting after chemotherapy with cisplatin. In about one third of patients, however, control of emesis is inadequate. Dexamethasone has been shown to enhance the effect of ondansetron in animals. Smyth *et al* (p 1423) studied the effect of dexamethasone on the efficacy of ondansetron in 100 patients receiving chemotherapy with cisplatin for the first time. Complete or major control of acute emesis (within 24 hours of treatment) was achieved in 49 out of 71 (69%) patients when dexamethasone was given with ondansetron compared with 40 out of 71 (56%) with ondansetron alone. Of those patients who expressed a preference, 72% preferred the combination treatment. It seems that addition of dexamethasone to the antiemetic treatment makes chemotherapy with cisplatin more acceptable to patients.

Bronchodilator treatment in asthma and chronic bronchitis

Current advice on the use of bronchodilator treatment is based on short intervention studies and the effectiveness of long term treatment has not been evaluated. On p 1426 van Schayck *et al* report the results of a two year randomised controlled study of the effects of salbutamol or ipratropium bromide bronchodilator treatment given continuously or on demand on the progression of asthma and bronchitis. Continuous treatment with either bronchodilator resulted in accelerated decline in FEV_1 in both conditions. Though bronchial responsiveness increased slightly, exacerbations, symptoms, and perceived quality of life remained unchanged. The authors suggest that continuous bronchodilator treatment without additional treatment accelerates decline in ventilatory function and that its use to relieve symptoms may mask the decline and mislead both doctor and patient.

Does intensified insulin treatment cause brain damage?

Some retrospective or cross sectional studies have suggested that insulin induced hypoglycaemia in patients with insulin dependent diabetes might lead to cognitive impairment. It is therefore important to know whether patients whose diabetes is treated more intensively than normal to avoid long term complications are at increased risk of brain damage. On p 1439 Reichard *et al* report the results of a prospective trial in which 96 patients were randomly allocated to intensified or standard treatment. At entry and after five years they went through a computerised battery of neuropsychological tests. The more intensively treated patients had lower blood glucose concentrations and less progression of microvascular complications but an increased frequency of serious hypoglycaemic episodes. This, however, did not lead to any signs of neuropsychological deterioration. The authors conclude that intensified insulin treatment over five years does not cause brain damage despite an increased frequency of hypoglycaemia.

Rates and risks associated with hip replacement

There is little published information on operative rates of total hip replacement and no accessible data on postoperative mortality and emergency readmissions. Seagroatt *et al* (p 1431), by using the Oxford record linkage study data for 1976-85, found that the operative rate had increased over time from 43 to 58 operations/100 000 population. The postoperative mortality within 90 days after the operation was 11/1000 operations and the emergency readmission rate after 28 days 28/1000 operations. Most of the excess postoperative deaths were attributed to cardiovascular causes; thromboembolic disease was the reason for many of the readmissions. These substantial figures suggest a need for investigation into reducing the incidence of these adverse postoperative events.

Cost effectiveness of magnetic resonance imaging

Magnetic resonance imaging is a potentially useful diagnostic technique in the neurosciences, but it is expensive. Szczepura *et al* (p 1435) monitored the cost effectiveness of West Midlands imaging service during its first year. Magnetic resonance imaging improved consultants' confidence in their diagnoses and management and resulted in changes in diagnosis in a fifth of cases and management changes in over a quarter. However, the cost per patient increased and there was no measurable improvement in patients' quality of life. Careful consideration needs to be given to how magnetic resonance imaging is used and the degree of diagnostic workup necessary. Audit is essential, and agreed techniques for monitoring cost effectiveness need to be developed.

Co-amoxiclav in recurrent acute otitis media

Recent studies have challenged the role of antibiotics in the treatment of acute otitis media. But the validity of antibiotic treatment in patients at high risk of complications is less clear. Appelman *et al* report a placebo controlled study of treatment with co-amoxiclav in children aged 6 months to 12 years with recurrent acute otitis media (p 1450). For children over 2 years the antibiotic made no difference to clinical recovery with 7% having fever or earache, or both, at day 3. For children aged 6 months to 2 years antibiotic seemed to improve the clinical course, although the difference between the placebo and antibiotic groups was not significant. The authors conclude that antibiotics should continue to be prescribed for children under 2 years with recurrent otitis media until conclusive evidence is available but they are not necessary in older children unless no improvement is seen after three days.