This week in BMJ

All communications to:
The Editor, *BMJ*
BMA House,
Tavistock Square
London WC1H 9JR
Fax: 071 383 6418
Phone: 071 387 4499

Aspirin may prevent colorectal cancer

BMJ readers may be suffering reader fatigue as yet more beneficial or adverse effects of aspirin are reported. Nevertheless, several epidemiological studies have suggested that regular users of aspirin and other non-steroidal anti-inflammatory drugs have a reduced risk of developing colorectal cancer. Most colorectal cancers develop from adenomatous polyps, and on p 285 Logan *et al* examine the relation between adenomas and analgesics using data collected during a case-control study of diet and colorectal adenomas. Patients with adenomas reported taking less aspirin and non-steroidal anti-inflammatory drugs compared with control subjects, and the risk of having an adenoma was roughly halved with their use. The risk was lower the greater the consumption of aspirin and non-steroidal anti-inflammatory drugs and was specific to these drugs, there being no association with paracetamol. These findings support the hypothesis that aspirin and non-steroidal anti-inflammatory drugs protect against colorectal cancer, possibly by reducing the prevalence of colorectal adenomas.

Migraine is a risk factor for stroke in young women

Migraine has long been suggested as a risk factor for stroke. Given the high prevalence of these two conditions, their occurrence in the same patient could however be a mere coincidence. The whole issue is obscured by the lack of agreement about the diagnosis of migraine. Tzourio *et al* (p 289) carried out a case-control study of the relationship beween ischaemic stroke and migraine based on the new classification of the International Headache Society. They interviewed 212 patients with ischaemic stroke and 212 matched controls and asked about their histories of headache. As a whole, the prevalence of migraine was similar in the two groups. The risk of ischaemic stroke was, however, significantly increased in young women with migraine, especially if they were smokers.

Managing hyponatraemic encephalopathy

Hyponatraemia is the most frequent electrolyte abnormality in hospital patients. Though it is often benign, if central nervous system symptoms occur treatment is mandatory to prevent brain damage. Major determinants of brain damage are the age and sex of the patient. Reviewing hyponatraemia and its management, Arieff (p 305) reports that though common clinical settings include AIDS, psychogenic polydipsia, and diuretic abuse, the postoperative state is the most frequent cause. He also finds that asymptomatic hyponatraemia generally does not require aggressive treatment, but when there are symptoms respiratory arrest with hypoxia is a major threat which can lead to brain damage and must be prevented. Treatment is hypertonic sodium chloride given over 24-48 hours, often in conjunction with a loop diuretic, aimed at correcting the serum sodium to modest hyponatraemia while limiting the absolute increase to 25 mmol/l. The rate of correction of hyponatraemia is not a factor in brain injury, and most brain damage is due to associated hypoxaemia.

Unhealthy lifestyle leads to early death in diabetes

People with non-insulin dependent diabetes have been shown to have twice the risk of early death compared with the general population. On p 295 Balkau *et al* examined known risk factors in a population of middle aged men who had diabetes or had had their glucose tolerance measured. After follow up for an average of 15 years they found that risk of death increased with increasing glucose intolerance. However, the risk was lower in men known to have diabetes than in those who had it diagnosed after the glucose tolerance test. The risk factors for early death were the same as in normoglycaemic men but high insulin concentration and mean corpuscular volume carried twice the risk in diabetic men. Good glycaemic control and a healthy lifestyle should increase chances of longevity in non-insulin dependent diabetes.

Muslims with non-insulin dependent diabetes can fast safely during Ramadan

A basic principle of Islam is fasting from sunrise to sunset of the month of Ramadan. This, however, poses problems for those with diabetes who do not accept the exemption allowed to patients with certain illnesses. Belkhadir *et al* (p 292) studied patients with non-insulin dependent diabetes who were being treated with glibenclamide. The patients adequately controlled their diabetes during Ramadan by reversing their normal regimen: they took their usual morning dose in the evening after breaking their fast and took their usual evening dose before dawn.

Guidelines shouldn't impose unrealistic standards

Clinical guidelines are used to inform doctors "of the right thing to do," though they have many different aims. Some are aimed at reducing the risk of litigation, others at reducing variation among doctors, and others at improving outcomes. As Andrew Farmer explains in his article on medical practice guidelines on p 313, much of the early work on guidelines was done in the United States. There guidelines have long been used to try to control the behaviour of the medical profession and contain costs, as well as in helping to improve the effectiveness of treatments. As British doctors start to develop and disseminate guidelines he argues that they can learn much from the Americans. In particular he emphasises that guidelines must be adapted to the routine working practices of most doctors, or they will fail.