

ABSTRACTS

COMPLEMENTARY AND ALTERNATIVE MEDICINES IN COPD

Australia, in common with many other countries, has seen an increasing use of complementary and alternative medicines (CAM) among all patients. Chronic respiratory problems are among their leading health problems, but there is little research to support the use of CAM in these illnesses. Chronic obstructive pulmonary disease (COPD) is the fifth leading cause of death worldwide and accounts for more than 4% of all deaths in Australia. Also in Australia, COPD is one of the main disabling conditions among men over the age of 65.

The authors of this study report that among the various CAM preparations, only ginseng, used in combination with normal respiratory medications, has any proven clinical efficacy in COPD. But, there is a high potential for interaction with drugs such as warfarin, digoxin, nifedipine, loop diuretics and monoamine oxidase inhibitors that makes its use potentially more harmful than beneficial.

Johnson George and colleagues set out to investigate the use of and patient's beliefs about CAM in a cross-sectional study of 173 patients with moderate to severe COPD. Of these, 71 (41%) said they were using some form of CAM, usually multivitamins and minerals. Garlic was the most commonly used herbal preparation. Their major source of information was advertisements and others with prior experience of using CAM. The patients used CAM to promote general well-being to counteract drug side-effects, to compensate for dietary deficiencies and to ameliorate their disease. It appeared that efficacy was less important to the users than safety. CAM practitioners were regarded as being more convincing, more informative and more considerate and available compared with allopathic doctors.

The authors concluded that communication between patients and their normal doctors about using CAM could be improved and that health professionals need to know more about CAM products.

George J, *et al.* *MJA* 2004; **181**: 248-251.

LACTOBACILLUS AND POST-ANTIBIOTIC CANDIDIASIS

Candida infection in the vagina is a common problem in women who have to take a course of antibiotics. Various remedies have been proposed, one of them oral or vaginal lactobacillus. Conventional wisdom has it that this can help preserve the normal flora of the vaginal tract but to date there has been no objective evidence for this. Marie Pirota and colleagues set out to test this supposition using a randomised, placebo-controlled, double-blind trial.

The team used women from 50 general practices and 16 pharmacies in Melbourne, Australia. The 278 participants were non-pregnant women aged 18 - 50 who needed a short course of oral antibiotics for a non-gynaecological infection. They were given either oral or vaginal lactobacillus or placebo from enrolment to 4 days after they finished their course of antibiotics. They found that overall, 55 out of 235 women developed post-antibiotic vulvovaginitis. Compliance with both the antibiotics and the intervention was high. However, the trial was stopped early because it soon became apparent that the lactobacillus had no effect as, statistically, the chances of developing vulvovaginitis was the same for women using lactobacillus and placebo.

The conclusion was that using oral or vaginal forms of lactobacillus to prevent post-antibiotic vulvovaginitis was not supported by the study results.

Pirota M, *et al.* *BMJ* 2004; **329**: 548.

MAMMOGRAMS — AGAIN

The vexed question of how, when and why to use mammograms to screen for breast cancer was also addressed in the Million Women Study. Emily Banks and her colleagues set out to examine how lifestyle, hormonal and other factors influence the sensitivity and specificity of mammography. Using women recruited to the Million Women Study, they asked participants to complete a questionnaire about various personal factors before routine mammography screening. They followed a sample of 122 355 women aged 50 - 64 years for the outcome of screening and incident breast cancer over the next 12 months.

They found that breast cancer was diagnosed in 726 of the women (0.6%); 629 in screen-positive and 97 in screen-negative women. Of the women, 3 885 (3.2%) were screen-positive but had no subsequent diagnosis of breast cancer. Overall sensitivity was 86.6% and specificity was 96.8%. There were 3 factors that had an adverse effect on both measures: the use of hormone replacement therapy, previous breast surgery versus no breast surgery, and body mass index either above or less than 25. Neither sensitivity nor specificity varied significantly according to age, family history of breast cancer, past oral contraceptive use, tubal ligation, physical activity, smoking or alcohol consumption.

The authors concluded that the efficiency and possibly the effectiveness of mammographic screening is lower in women using hormone replacement therapy, in women with previous breast surgery and in thin women compared with other women.

Banks E, *et al.* *BMJ* 2004; **329**: 477.

WOMEN'S REASONS FOR NOT RETURNING FOR FOLLOW-UP BEFORE STARTING PREVENTION OF MTCT TREATMENT

A study from Côte d'Ivoire suggests that difficulties experienced by women during contact with staff from a programme that intends to prevent transmission of HIV from mother to child can prevent them from participating in prophylaxis. Researchers used a sample of 27 women who had been found to be HIV-1 positive and who were invited to return for monthly follow-up before starting prophylaxis with zidovudine at 36 weeks' gestation. These women had either refused or discontinued the visits. None of them started prophylaxis. As the authors point out, there is increasing availability of interventions to prevent transmission of HIV from mother to child in Africa, but many women do not participate.

The programme from which these women were studied included group counselling before HIV testing, conducted by trained social workers. These sessions were followed by private sessions with social workers during which individual women accepted or refused HIV testing. The women were followed up 2 weeks after testing either by the social workers or by programme doctors. Those who were HIV-1 positive were offered monthly follow-up visits with a programme midwife before starting free prophylaxis with a short course of zidovudine at 36 weeks and zidovudine before and during labour.

The women taking part in this study had no further contact with programme staff, but saw staff at the clinic for other consultations before and after giving birth. The women were seen by a programme doctor who asked if they were interested in being interviewed and took those who said yes to see an interviewer privately. Of the 27 women, 24 described their interactions with programme staff or their views about the programme when explaining their refusal or discontinuation of follow-up visits. Another 14 women did not believe their positive HIV test results, and 4 of the women described personal factors.

Some women were not happy with how HIV testing had been explained, some were afraid of the staff and 4 could not find programme staff when they came back for follow-up. Other women reported that they did not believe that the prophylaxis was effective and were also concerned about mistakes being made with the blood collected for HIV testing. Still others did not believe that they were HIV positive because they thought they had no risk factors for infection. Their responses, according to the authors, indicate the importance of a positive outlook among the staff and clear explanations of the programme's procedures. It is also important that programme staff have up-to-date information on the interventions they are proposing to the women. As far as women not believing their test results, programme staff need to explain the risk factors for HIV infection well and fully.

The authors point out that this is the first study in Africa that has addressed the reasons why HIV-positive women may not return for follow-up to receive antiretroviral prophylaxis to prevent MTCT. The barriers described in this paper may be contributing to persistently low levels of participation in prevention of MTCT programmes. The authors suggest that more research is needed in this area to clarify and address programme-related barriers to protecting African infants from HIV infection.

Painter T, *et al.* *BMJ* 2004; **329**: 543.

Bridget Farham