1- Earlier Intervention in the Management of Hypercholesterolemia: What are we Waiting For?

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The thesis advanced here is that we are initiating treatment of hypercholesterolemia (and other risk factors) too late in life. Initiating treatment at, for example, age 30 years instead of age 60 years might very well prevent not just 30% of events, as in the 5-year statin trials, but perhaps as many as 60%.

2- Pericardial Fat Is an Independent Predictor of AF

August 23, 2010 (New Haven, Connecticut)

Pericardial fat might provide additional information on a patient's risk of atrial fibrillation, results of a 273-patient computed tomography study published in the *Journal of the American College of Cardiology* .

3- What are the currently approved treatments for metastatic melanoma?

NEJM August 24 ,2010

The two therapies approved by the Food and Drug Administration, high-dose interleukin-2 and dacarbazine, are each associated with response rates of only 10 to 20% and a small percentage of complete responses; neither is thought to improve overall survival. In randomized trials, the median survival among patients treated with dacarbazine was less than 8 months

4- Reduce Warfarin Dose When Kidney Function Is Impaired:

Karla Gale, MS

BMJ 2010; 341:c4407 Published 27 August 2010)

August 27, 2010 — Patients with renal impairment require lower warfarin doses, and now researchers have published some recommendations to help guide management in these cases.

Patients with moderate kidney impairment required nearly 10% lower doses, while those with severe impairment needed dose adjustments of about 20%, they said in an August 16th online article in the *American Journal of Kidney Diseases*.

5- Septic arthritis in children- Easily Missed?

BMJ 2010; 341:c4202 doi: 10.1136/bmj.c4202 (Published 25 August 2010)

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differential diagnosis of septic arthritis in children can be difficult, but early treatment of joint infections avoids potentially disabling complications

Septic arthritis accounts for a small minority of the myriad musculoskeletal problems in childhood which primary care doctors will evaluate. Joint infections are best treated early to avoid potentially disabling complications. The earlier the presentation, the more difficult it is to distinguish an infection from benign, self limited conditions such as transient synovitis of the hip

6- Should treatment for heart failure with preserved ejection fraction differ from that for heart failure with reduced ejection fraction?

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Heart failure with preserved ejection fraction (HF-PEF) accounts for about half of all cases of heart failure.1 Population based studies have shown that patients with HF-PEF have high rates of mortality (20-30% risk at one year)2 3 and readmission to hospital

(30% risk at 60-90 days),4 which are similar to the rates for patients with heart failure with reduced ejection fraction (HF-REF). When compared with patients with HF-REF, those with HF-PEF are older, more often female, and more likely to have hypertension and atrial fibrillation, but are less likely to have coronary artery disease.2 3 Identifying patients with HF-PEF can be difficult, however, because heart failure presents in many different ways and the diagnostic criteria that define this syndrome are complex.5 The guideline from National Institute for Health and Clinical Excellence has proposed detailed guidance on diagnosis.6 In practice, the diagnosis of HF-PEF is often made in patients with symptoms and signs of heart failure who have preserved left ventricular ejection fraction. Furthermore, the evidence that supports treatment for HF-PEF is much weaker than that supporting treatment for HF-REF. To date, results from existing clinical trials of HF-PEF have been largely inconclusive, and treatments that have been shown to reduce morbidity and mortality in patients with HF-REF showed either no or only marginal benefits in patients with HF-PEF.

7- Managing gastrooeso-phageal reflux in infants

BMJ 2010; 341:c4420 doi: 10.1136/bmj.c4420 (Published 27 Augu

- Gastro-oesophageal reflux is common in infants, particularly preterm babies, younger infants, and those with neurodevelopmental disorders
- Reflux is usually self limiting and without complications. Occasionally, it is associated with troublesome symptoms or complications (such as respiratory disorders or suspected oesophagitis), when it is known as gastro-oesophageal reflux disease (GORD)
- Parental education and reassurance, changes in feeds, thickening of fluids, or an alginate combination should be tried first for managing GORD. Infants whose symptoms are unresponsive, or those with complications, should be referred to specialist paediatric services for investigation
- An H_2 receptor antagonist to reduce acid secretion may be needed to control the condition, but there is little evidence to support such therapy. Ranitidine, which is licensed for use from 6 months of age, is now recommended by the *BNF for Children* as the most suitable such drug for infants
- If an H_2 receptor antagonist is unsuccessful, the next step is treatment with omeprazole (unlicensed in infants) or surgery
- No other drugs are licensed or recommended for GORD in infants