In this issue

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DRUG-ELUTING STENTS: NOT FOR EVERYONE

The practice of treating almost all privately insured patients who require percutaneous revascularisation with drug-eluting rather than bare-metal stents needs to be reviewed, says Harper (*page 253*). At four times the price of bare-metal stents, drug-eluting stents, with their lower rates of restenosis, have been used preferentially in patients who have health insurance. A newly recognised drawback, however, is that patients with drug-eluting stents require at least 6–12 months of dual antiplatelet therapy, to prevent the far more serious complication of stent thrombosis.

CANCER PATIENTS WANT TO TALK ABOUT SEX

While many people with cancer would appreciate the opportunity of discussing issues of intimacy and sexuality, health professionals often lack the skills to embark on such a conversation. After interviewing 50 cancer patients and 32 health professionals in Victoria, Hordern and Street (*page 224*) note that there is often a mismatch between what patients want to talk about and what health professionals are willing to discuss. The solution? Health professionals need to engage in an exploration of their own definitions of intimacy and sexuality, and how these affect their professional world and their interactions with patients.

IMPROVING CLINICAL CARE

In this issue of the *MJA*, we're launching a new category of articles that will examine how we can do things better. As editors, we sometimes receive articles describing research that we know is not new but which underscores an important point or highlights an issue in health care that is ripe for improvement. The first article, a study which found that most patients admitted to an Australian teaching hospital with an exacerbation of chronic obstructive pulmonary disease (COPD) were given too much oxygen, is a classic example. Current guidelines recommend that such patients receive a maximum oxygen flow rate of about 2L per minute, but Joosten et al (*page 235*) discovered that most patients treated for COPD exacerbations at their hospital received higher flow rates than this, either on the way to hospital in the ambulance or in the emergency department. When arterial blood gases were measured, 41 of the 65 patients were classified as retaining carbon dioxide: all but two of these had received oxygen at greater than 2L per minute. A timely reminder, says Young (*page 239*), of the importance of avoiding the induction of hyperoxic hypercapnia in patients with acute-on-chronic respiratory failure. For future *Improving Clinical Care* articles, we are seeking papers that have a clear message, immediate clinical application, and the potential to be integrated into practice without undue debate.

ANOTHER TIME ... ANOTHER PLACE

Where prolonged administration of oxygen seems desirable, the minimum quantity of oxygen which will remove the cyanosis should be carefully ascertained by observation of the patient, and [be] adjusted to give this minimum quantity, which is likely to be anything from 1 to 3 litres per minute.

John Scott Haldane, *BMJ*, 1917

INSULIN LEVELS: THE DEBATE CONTINUES

An article arguing against measuring insulin levels in patients with suspected insulin resistance, published in the *MJA* last August, has generated some interesting correspondence (*page 268*). From women with polycystic ovary syndrome to obese adults and children, there is a range of patients in whom some clinicians believe measuring insulin levels is justified. In response, the authors of the original article stick to their guns: this test should be used in epidemiology and research, not in clinical practice.

URBAN/PRIVATE PATIENTS HAVE FEWER DOWN SYNDROME BIRTHS

Queensland women living in rural areas or using public antenatal care are more likely than urban or privately insured women to give birth to a baby with Down syndrome, say Coory et al (*page 230*). Examining the Queensland Perinatal Data Collection, these researchers found that the rates of age-adjusted Down syndrome births decreased between 2000 and 2004 by 14.3% per year in urban women and 27.5% per year in women cared for by private obstetricians, while the rates in rural and public patients were essentially unchanged. Possible reasons for the discrepancy include differences in access or attitudes to screening and/or pregnancy termination.

Dr Ruth Armstrong, MJA