In this issue

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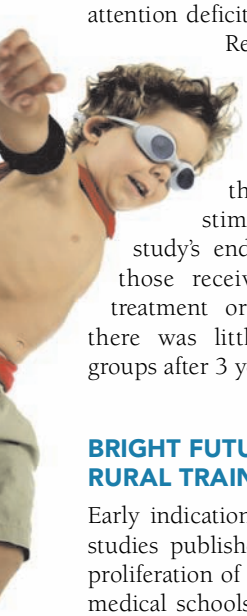
BLANKET APPROACH TO STDs?

While many remote Indigenous communities have screening and treatment programs for sexually transmitted diseases (STDs) such as chlamydia, gonorrhoea and trichomoniasis, the prevalence of these infections often remains high. It's time for a new approach, say Bowden and Fethers (*page 182*). If the World Health Organization recommends whole-of-community treatment for trachoma control, why shouldn't we institute it for the three commonest STDs?

NO MAGIC BULLET FOR ADHD

Stimulants can no longer be considered the mainstay of therapy for all children with attention deficit hyperactivity disorder, says Rey (*page 133*). A recent long-term follow-up of children with ADHD involved in the United States Multimodal Treatment Study revealed that, while children given stimulants did better by the study's end-point of 14 months than those receiving tailored psychosocial treatment or routine community care, there was little difference between the groups after 3 years.



BRIGHT FUTURE FOR RURAL TRAINING

Early indications from several small recent studies published in the *MJA* are that the proliferation of rural training options in our medical schools is not in vain. Particularly encouraging is the experience of Flinders University (Worley et al, *page 177*). Since 1996, students have been able to choose to do their entire third year at Flinders Medical Centre or in one of two rural settings. Those who responded to a survey in late 2005 were much more likely to be in training for rural practice if they had chosen the rural option as undergraduates. Also encouraging is the news that medical schools are beginning to join forces to build and nurture high-quality rural training, rather than competing for this scarce resource. Page et al describe such a venture on *page 179*.

FOR WHOSE BENEFIT?

In an article published last year, Richards and Rogers suggested several interventions that could be performed on potential cadaveric organ donors before death to maintain the viability of their organs. On *page 186*, in a feisty *Matters Arising*, readers debate the ethics of this practice.

DON'T "DIS" TB

In Australia in 2008, ask Bastian and Krause in this issue's lead editorial (*page 131*), why would the *MJA* editors see fit to devote so many pages to tuberculosis? Having raised this question, they go on to make a good argument for more focus on this disease, which, despite its rarity in Australia, affects our *dis*placed, *dis*advantaged, *dis*possessed and immunologically *dis*abled, and continues to be a major cause of morbidity and mortality for our not-so-*dis*tant neighbours.

Indeed, the ravages of TB are never far from our shores, as Gray et al found when looking at its occurrence in detained illegal Indonesian fishermen (*page 144*). While we are doing a good job of detecting TB in this group, we are failing to treat them adequately. Also to our north, Gilpin et al have detected cases of multidrug-resistant TB in residents of the Western Province of Papua New Guinea who sought treatment on two open-border islands in the Torres Strait (*page 148*).

One of the purposes of publishing these articles is to put TB on the radar of your clinical thinking. In this vein, Lim et al describe their justified suspicions in a case of granulomatous hepatitis (*page 166*), and Gupta et al remind us that TB should be excluded before starting patients with inflammatory diseases on tumour necrosis factor α inhibitors (*page 168*). As illustrated by Massasso and colleagues' challenging case of iliopsoas bursitis (*page 164*), this is not always straightforward.

Speaking of clinical radars, a diagnosis of TB should also get you thinking about HIV infection. Emerson and Post contend that all patients with proven TB should be offered an HIV test (*page 162*).

Finally, two studies look at TB in Australian hospitals. A search of the records of a Sydney chest clinic revealed the merits of the clinic's policy of directly observed therapy (Dobler et al, *page 153*). Among 848 patients with culture-positive TB between 1994 and 2006, three had recurrent disease: in two cases strains were different from the initial culture, suggesting reinfection during visits to high-incidence countries rather than reactivation, leaving only one case of true recurrence. And a Sydney children's hospital (*Letters, page 190*) has experienced an increase in cases of latent TB as the children of refugees have presented for testing, but no marked increase in active disease.

Many of these articles reveal advances in diagnosis, epidemiological expertise and therapy that Australia should be sharing with the world — or at least our little corner of it — a challenge that we should not *dis*miss.

Dr Ruth Armstrong, MJA

ANOTHER TIME … ANOTHER PLACE

Five phrenicotomies in humans have shown that his operation is simple to perform and not severe on the patient… The first patient suffered from advanced tuberculosis on the right side of the lung… The interruption of the phrenic nerve relieved the annoying compulsive cough, which ceased at once… In the fourth and fifth cases, both with tuberculosis, the coughing stopped and the sputum decreased after the phrenicotomy.

Ernst Ferdinand Sauerbruch, 1913