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CONFLICTING EVIDENCE

What happens when evidence-based medicine clashes with long-established clinical wisdom? Such a scenario has been played out in the Journal over recent months. In November last year, a commissioned editorial summarised the results of two recent randomised controlled trials of vertebroplasty for the treatment of painful osteoporotic spinal fractures, concluding that the procedure was no better than placebo. This summary, from the trials' lead authors, proved controversial, attracting a number of responses that have already been aired in our letters pages. We now publish a rejoinder from Australian vertebroplasty experts Clarke and colleagues (*page 334*), who argue that the research was not directly relevant to the patients they treat with vertebroplasty. Buchbinder et al make a point-by-point response on *page 338*, defending their summary of the trials as an accurate portrayal of the best available evidence. Our Editor, Van Der Weyden, welcomes debate, but says it is incumbent on detractors to back up their arguments with hard data (*page 301*).

THE COMPLEXITIES OF COMPENSATION

The link between access to compensation and poor recovery after injury may not be as simple as previously thought (*page 328*). O'Donnell and colleagues compared outcomes for compensable and non-compensable patients admitted to two hospitals in Victoria with moderate-to-severe injuries. Under the state's Transport Accident Commission compensation scheme, 246 patients were considered compensable and 145 non-compensable at baseline. After 2 years, the compensable patients were significantly more likely to have post-traumatic stress disorder, depression and anxiety, and were less likely to have returned to their usual hours of work. It was also discovered at follow-up, however, that many non-compensable patients had accessed private health insurance or other forms of compensation, such as that for victims of crime. When these patients were removed from the non-compensable group, the differences in outcomes were minimal.

FLYING BLIND

Patchy data collection means that Australia lacks accurate national data on congenital anomalies, say Bower and colleagues (*page 300*). The authors argue that this problem hampers our ability to monitor trends, identify clusters, evaluate the effectiveness of screening and interventions, and conduct research into prevention.

BIG TICK FOR HEART FAILURE MANAGEMENT

The treatment of heart failure is becoming increasingly evidence-based but would be even better if more patients underwent echocardiography while in hospital. So say Teng and colleagues after reviewing hospital morbidity and death registry data for just over 1000 patients with heart failure admitted to three Perth tertiary hospitals between 1996 and 2006 (*page 306*). The overall prescription rate of angiotensin-converting enzyme inhibitors/angiotensin receptor blockers (74.3%) and loop diuretics (85.5%) was consistently high. Prescription of β-blockers and spironolactone increased (from 10.5% to 51.3% and from 1.4% to 23.3%, respectively), and digoxin prescription decreased (from 38.1% to 20.7%) over the study period, in line with emerging clinical trial evidence. Patients who had in-hospital echocardiography (53%) had the best chance of receiving evidence-based therapies, which, in turn, was associated with a lower risk of mortality at 1 year.

Dr Ruth Armstrong, MJA

ANOTHER TIME ... ANOTHER PLACE

Evidence-based medicine, whose philosophical origins extend back to mid-19th century Paris and earlier, is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

David L Sackett, 1997

HIP FRACTURE QUANDARY

Employing a dedicated nurse to oversee hip fracture prevention strategies in aged care facilities does not appear to be effective. So say the investigators in a cluster randomised controlled trial of aged care facilities in NSW (Ward et al, *page 319*). In the trial, a project nurse promoted falls risk assessment; mobility assessment; use of hip protectors; calcium and vitamin D supplementation; continence management; exercise programs; appropriate footwear; medication review; and post-fall management review in 46 of 88 participating aged care facilities, while the remaining facilities were asked to deliver usual care. Over 17 months, both intervention and control facilities increased their use of hip protectors and vitamin D supplementation, but there was no change in the rates of falls or falls injuries. The authors concluded that a longer trial might be warranted but that, without improved funding and staffing of aged care facilities, promotion of falls prevention measures was unlikely to be effective.

AN ISSUE OF DILEMMAS

If the conflicts and quandaries detailed above aren't enough for you, dip into some of the dilemmas detailed elsewhere in this issue: having to play policeman with your patients with epilepsy (Somerville, *page 342*); an emerging cause of chronic skin ulcers in patients from the Pacific island region that can be difficult to diagnose (Peel et al, *page 348*); or Indigenous Australians going blind from preventable causes (Taylor et al, *page 312*). And there's even more in Letters (*page 354*) Iannuzzi suggests that the most efficient way to fund Indigenous health would be to follow the DVA's excellent "Gold Card" model. Emergency physicians are not convinced that the proposed "acute medical assessment and admission units" will do anything to solve the problem of access block, and Egger (and over 300 cosignatories) call on the government to join with health professionals to urgently address the health consequences of obesity and climate change (*page 359*).