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News

Prof. Tom Fahey during a panel session "Clinical Prediction Rules in the Cochrane Primary Health Care Field" on the annual scientific meeting of SAPC in Norwich (UK) July 7th.

P.E.A.R.L.S.

practical evidence about real life situations

The New Zealand Guideline Group fund the Cochrane Primary Care Field to produce the P.E.A.R.L.S. (click here for the websitelink)

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The actual Cochrane abstracts for the P.E.A.R.L.S are at

162. Corticosteroid injections effective for trigger finger

163. Rehabilitation interventions effective for older people in long term care

164. Clinical trials subject to publication bias

165. Insufficient evidence for benefits of very early mobilisation after stroke

Colophon

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Abstracts

Corticosteroid injections effective for trigger finger

Clinical question	How effective are corticosteroid injections for trigger finger (stenosing tenosynovitis) in adults?
Bottom line	Intra-tendon sheath corticosteroid injection with lidocaine was more effective (37%) than lidocaine alone (17%) on treatment success at 4 weeks (NNT* 3). No adverse events or side effects were reported. In 1 study, the effects of corticosteroid injections lasted up to 4 months. *NNT= number needed to treat to benefit 1 individual

Caveat	The methodological quality of the 2 studies included was poor and there were some flaws in the quality of reporting. The 2 trials were performed in the setting of secondary care and generalisability to other settings (eg, primary care) remains to be established.
Context	Trigger finger (stenosing tenosynovitis) is a disease of the tendons of the hand leading to triggering, snapping or locking of affected fingers, dysfunction and pain. The lifetime prevalence of trigger finger among a group of non-diabetics above the age of 30 years has been estimated at 2.2%. Available treatments include local injection with corticosteroids, surgery or splinting.
Cochrane Systematic Review	Review Peters-Veluthamaningal C et al. Corticosteroid injection for trigger finger in adults. Cochrane Reviews 2009, Issue 1. Article No. CD005617. DOI: 10.1002/14651858.CD005617.pub2. This review contains 2 trials involving 63 participants.
PEARLS 162, May 2009, written by Brian R McAvoy	

[References]

Rehabilitation interventions effective for older people in long term care

Clinical question	How effective are physical rehabilitation interventions directed at improving physical function among older people (age range 69 to 89 years) in long term care?
Bottom line	The included studies provide evidence physical rehabilitation interventions for elderly people residing in long term care can be both safe and successful, improving both physical and mental state. Most interventions addressed disability in routine activities of daily life, eg, walking, eating and dressing. The trial outcomes addressed by this review were: disability in daily life; strength; flexibility; balance; general physical condition; mood; cognitive status; participant withdrawal rate; session attendance; death; illness; and unwanted effects associated with the intervention, such as injuries. Most interventions lasted less than 20 weeks, and comprised approximately three 30 to 45-minute group sessions per week. While variations between the trials means specific recommendations cannot be made, the trial results were overwhelmingly successful.

Caveat	Due to the wide variety of outcome measures used, the studies could not be summarised statistically. There is insufficient evidence to make recommendations about the best intervention, improvement sustainability and cost-effectiveness.
Context	The number of over 65-year-olds constituted 6.6% of the world's population in 1997 and is predicted to increase to 10% by 2025. It is expected this will lead to a rise in demand for long term residential care. There is, therefore, a demand for ways of preventing any deterioration in health, and for increasing independence in activities of daily living, eg, walking and dressing, among residents.
Cochrane Systematic Review	Forster A et al. Rehabilitation for older people in long term care. Cochrane Reviews 2009, Issue 1. Article No. CD004294. DOI: 10.1002/14651858.CD004294.pub2. This review contains 49 trials involving 3611 participants.
PEARLS 163, April 2009, written by Brian R McAvoy	

[References]

Clinical trials subject to publication bias

Clinical question	Is publication of clinical trials influenced by the statistical significance, perceived importance or direction of their results?
Bottom line	Trials with positive findings are published more often, and more quickly, than trials with negative findings. The authors of the review predicted, if 41% of negative trials were published, they would expect 73% of positive trials to be published. The size of the trial and the source of funding, academic rank, and sex of the principal investigator did not appear to influence whether a trial was published. The prospective registration of all clinical trials at inception and before their results become available would enable review authors to know when relevant trials have been conducted, so that they could ask the responsible investigators for the relevant study data.
Caveat	Those conducting systematic reviews should ensure they assess the potential problems of publication bias in their review, and consider methods for addressing this issue

	by ensuring a comprehensive search for both published and unpublished trials.
Context	The tendency for authors to submit manuscripts, and of journals to accept manuscripts for publication based on the direction or strength of the study findings, has been termed publication bias. Such bias can threaten the validity of a systematic review's conclusions.
Cochrane Systematic Review	Hopewell S et al. Publication bias in clinical trials due to statistical significance or direction of trial results. Cochrane Reviews 2009, Issue 1. Article No. CD000006. DOI: 10.1002/14651858. CD000006.pub3. This review contains 5 studies involving 750 clinical trials.
PEARLS No. 164, April 2009, written by Brian R McAvoy	

[References]

Insufficient evidence for benefits of very early mobilisation after stroke

Clinical question	How effective is very early mobilisation after stroke (commenced within 48 hours of stroke) compared to conventional care?
Bottom line	There is insufficient evidence regarding the benefits or harms of very early mobilisation after stroke to make any recommendation on the practice. One small trial found no difference in death and dependency at 3 months between those who undertook an early intensive mobilisation protocol and those who did not. No significant harms were identified, and a small reduction in non-serious adverse events was found. No significant difference on any secondary outcome of interest was found (quality of life, patient mood, performance of activities of daily living, requirement for institutional care, or time to walking unassisted).
Caveat	The review found only 1 small trial which met the inclusion criteria. Nineteen relevant trials from China failed to meet the inclusion criteria.
Context	Care in a stroke unit is recommended for patients early after stroke and results in reduced disability and an increased likelihood of returning home. Very early mobilisation (helping patients to get up out of bed very early and often after stroke symptom onset) is undertaken in some stroke units and is recommended in

	many acute stroke clinical guidelines. It is unclear whether very early mobilisation independently improves outcome after stroke.
Cochrane Systematic Review	Bernhardt J et al. Very early versus delayed mobilisation after stroke. Cochrane Reviews 2009, Issue 1. Article No. CD006187. DOI: 10.1002/14651858.CD006187.pub2. This review contains 1 study involving 71 participants.
PEARLS No. 165, June 2009, written by Brian R McAvoy	

[References]