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- Antibiotics for acute diverticulitis
- Locally applied haemostatic agents in the management of acute epistaxis
- Apomorphine for the treatment of erectile dysfunction
- Crisis interventions for borderline personality disorder

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

210. Topical glyceryl trinitrate may be effective in rotator cuff disease

211. Thiazides best first choice for hypertension

212. Insufficient evidence for statins in age-related macular degeneration

213. Insufficient evidence for interventions for post-stroke fatigue

Colophon

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Abstracts

Topical glyceryl trinitrate may be effective in rotator cuff disease

Clinical question	How effective is topical glyceryl trinitrate (GTN) for rotator cuff disease?
Bottom line	Three small studies, 1 at moderate risk of bias and 2 at high risk of bias, assessed the effectiveness of GTN but each reported different treatment regimens and different outcome measures. They also included participants with differing duration of symptoms. There is some evidence from 1 study at high risk of bias that topical GTN is more effective than placebo for rotator cuff disease among patients with acute symptoms (less than 7 days' duration), but there is insufficient evidence to be certain about longer term effects. Headache was a common side effect in 1 trial and any benefits of treatment need to be balanced against the risk of headache.
Caveat	The inclusion criteria varied between studies and the selective reporting of outcomes limited the analysis of the available data. The effects on pain of GTN patches

	(1.25mg/day), along with rehabilitation instruction (such as exercise) and of GTN patches (5mg/day) compared to injection with corticosteroid and painkillers, were not reported by the studies included in the review. It is uncertain whether GTN patches (5mg/day) eliminate symptoms of rotator cuff disease because of the very low quality of the evidence. Improvement in people's physical function was not measured by any of the studies included in the review.
Context	Topical GTN has been used to treat chest pain for many years, and has been proposed as a promising treatment for muscle and tendon injuries. For treatment of soft tissue conditions, GTN is delivered topically, through the skin, using medicated patches.
Cochrane Systematic Review	Cumpston M et al. Topical glyceryl trinitrate for rotator cuff disease. Cochrane Reviews 2009, Issue 3. Article No. CD006355. DOI: 10.1002/14651858.CD006355.pub2. This review contains 3 studies involving 121 participants.
PEARLS No. 210, November 2009, written by Brian R McAvoy	

[References]

Thiazides best first choice for hypertension

Clinical question	What are the most effective first-line antihypertensive drugs?
Bottom line	First-line low-dose thiazides (eg, hydrochlorothiazide <50mg) are more effective than first-line high-dose thiazides (eg, hydrochlorothiazide 50mg or more) and first-line beta-blockers, in reducing mortality and morbidity (stroke, myocardial infarction and heart failure). For total cardiovascular events over 5 years, the NNT* is 20 in moderate to severe hypertension (>160/100mmHg) and the NNT is 120 in mild hypertension (140-160/90-100mmHg). Evidence for first-line ACE inhibitors is similar to low-dose thiazides but less robust, and ACE inhibitors are more expensive than thiazides. Evidence for first-line calcium channel blockers is insufficient. *NNT = number needed to treat to benefit 1 individual.
Caveat	Over 72% of participants in this review represent a primary prevention population.There are no randomised controlled trials comparing first-line use of other classes of drugs, such as angiotensin receptor blockers or alpha

	blockers.
Context	One of the major decisions involved in the management of patients with elevated blood pressure is which drug to choose first. The decision should be informed by the best available evidence of reduction of the outcomes that are important to the patient, ie, the ability of the drug to reduce the adverse health outcomes associated with elevated blood pressure (stroke, myocardial infarction and mortality).
Cochrane Systematic Review	Wright JM and Musini VM. First-line drugs for hypertension. Cochrane Reviews 2009, Issue 3. Article No. CD001841. DOI: 10.1002/14651858.CD001841.pub2. This review contains 57 studies involving 58,040 participants.
PEARLS No 211, October 2009, written by Brian R McAvoy	

[References]

Insufficient evidence for statins in age-related macular degeneration

Clinical question	How effective are statins in delaying the onset and/or progression of age-related macular degeneration (AMD)?
Bottom line	In the one completed trial, the analyses of 30 participants showed no statistically significant difference between the simvastatin and the placebo arm in visual acuity at 3 months of treatment or 45 days after the completion of treatment. The lens and retina status were unchanged during and after the treatment period for both groups. In the ongoing trial, the preliminary analyses of 42 participants who completed 12 months' follow-up did not show a statistically significant difference between the simvastatin and the placebo arm in visual acuity, drusen score or visual function (effect estimates and confidence intervals were not available).
Caveat	There were only 2 small studies, one of which is still ongoing.
Context	AMD is a progressive late onset disorder of the macula that affects central vision. Although AMD is the leading cause of blindness in people over 65 years in industrialised countries,1 its pathogenesis is not clearly understood. Recent epidemiologic, genetic and pathological evidence has shown AMD shares a number

	of risk factors with atherosclerosis, leading to the hypothesis that statins may exert protective effects in AMD.
Cochrane Systematic Review	Gehlbach P et al. Statins for age-related macular degeneration. Cochrane Reviews 2009, Issue 3. Article No. CD006927. DOI: 10.1002/14651858.CD006927.pub2. This review contains 2 studies involving 72 participants.
PEARLS No. 212, November 2009, written by Brian R McAvoy	

[References]

1. Congdon NG et al. JAMA 2003;290:2057-60

Insufficient evidence for interventions for post-stroke fatigue

Clinical question	How effective are interventions for post-stroke fatigue?
Bottom line	This review found 3 small, randomised controlled trials that recruited people with a stroke to 3 treatments - 2 different drug treatments (fluoxetine and tirilazad) and one chronic disease self-management programme. At follow-up, there was no difference in fatigue levels between the patients who received the active treatments and those who received usual care or placebo. However, the trials were too small to provide firm conclusions and further trials are required. Currently, there is insufficient evidence to guide practice in treating fatigue following stroke.
Caveat	There were only 3 completed studies, providing data on a total of 226 patients, and these involved 3 different interventions. There were methodological limitations with all 3 trials. It was not possible to perform meta-analysis as the interventions were too dissimilar.
Context	Estimates of the prevalence of fatigue after stroke range from 16%1 to 70%,2,3 depending on the population studied (eg, inpatients or community patients, time since stroke, severity of stroke), whether people with depression were included or excluded, and how fatigue was identified (eg, single question or fatigue scales).
Cochrane Systematic Review	McGeough E et al. Interventions for post-stroke fatigue. Cochrane Reviews 2009, Issue 3. Article No. CD007030. DOI: 10.1002/14651858.CD007030.pub2. This review contains 3 studies involving 226 participants.

PEARLS No. 213, November 2009, written by Brian R McAvoy

[References]

1. Glader E-L et al. Stroke 2002;33:1327-33.
2. Carllson GE et al. Cerebrovasc Dis 2003;16:383-88.
3. Leegard OF. Acta Neurol Scand 1983;67:348-55.