

Uterine artery embolization to treat fibroids usually successful

Clinical question What are the long-term outcomes for uterine artery embolization to treat uterine fibroids?

Bottom line Uterine embolization for the treatment of symptomatic uterine fibroids has a long-term success rate of 75% over the 5 years following treatment. This approach has the potential for avoiding the majority of hysterectomies for fibroid-caused symptoms and deserves further study. (Level of evidence = 2b)

Spies JB, Bruno J, Czeyda-Pommersheim F, et al. Long-term outcome of uterine artery embolization of leiomyomata. *Obstet Gynecol.* 2005;106:933-939.

Synopsis Uterine artery embolization is a less invasive intervention for the treatment of uterine fibroids than hysterectomy or myomectomy. In this cohort study, 200 women with uterine fibroids and associated symptoms were treated with uterine artery embolization. Women must have failed or had contraindications to medical therapy or refused it. Anatomic exclusion criteria were (1) pedunculated fibroids resectable by hysteroscopy and (2) uterine size greater than at 24 weeks' gestation. Symptoms could be one or more of the following: (1) heavy menstrual periods (with or without anemia); (2) pain; or (3) urinary symptoms associated with bladder or ureteral compression. Fibroid volume was calculated according to MRI of the pelvis performed prior to embolization and again 3 months after. Embolization was performed bilaterally until the vasculature of the fibroid was occluded and there was slow (near stasis) flow in the main uterine artery. Most women (78%) were older than 40 years, and 85% had 2 or more fibroids. Eighteen women (9%) were lost during the 5-year follow-up period. Treatment failure was defined as either the need for a hysterectomy, myomectomy, or repeat embolization or lack of improvement in symptoms. Treatment failed in 25% of cases. Better treatment outcome and patient satisfaction were associated with a fibroid volume reduction greater than 56% at 3 months compared with baseline. Better outcome was also associated with baseline fibroid volumes less than the median for the group (151 mL).

Topical tretinoin may hasten healing of diabetic ulcers

Clinical question Does brief daily application of tretinoin improve healing in diabetic foot ulcers?

Bottom line This small study provides some support for a daily 10-minute application of 0.05% topical tretinoin to diabetic ulcers. (Level of evidence = 1b)

Tom WL, Peng DH, Allaei A, et al. The effect of short-contact topical tretinoin therapy for foot ulcers in patients with diabetes. *Arch Dermatol.* 2005;141:1373-1377.

Synopsis Findings from uncontrolled studies have suggested that brief application of topical tretinoin (Retin-A) may improve healing in patients with chronic skin ulcers. In this small study, 24 patients with a diabetic foot ulcer but without evidence of peripheral vascular disease or infection were identified at a Veterans Affairs medical center. Groups were reasonably well balanced at the start of the study: The control group had a mean age of 61 years, mean duration of ulcer of 12 months, and mean ulcer size of 1.1 cm; those values for the intervention group were 58 years, 6 months, and 0.9 cm. The intervention group had 0.05% topical tretinoin applied for 10 minutes per day, followed by a saline rinse, for a total of 4 weeks. All wounds had cadexomer iodine gel applied between treatments with tretinoin or placebo ointment. After 16 weeks, wounds in the intervention group were 55% smaller and those in the control group were 3% larger (absolute values in terms of square centimeters are not reported). More ulcers were completely healed in the intervention group than in the control

group (6/13 versus 2/11; $P=.03$). Mild to moderate pain was a bit more common in the tretinoin group (3 versus 1), but this was not statistically significant in this small study.

Gargling with water reduces risk of colds

Clinical question Is gargling with water or povidone-iodine effective in preventing upper respiratory tract infections (URTIs)?

Bottom line Gargling with water effectively reduces the risk of developing an URTI. Nine individuals will need to gargle with water for 1 minute, 3 times daily, for 60 days to prevent one additional person from developing a URTI. Gargling with povidone-iodine was no more effective than usual care. (Level of evidence = 1b)

Satomura K, Kitamura T, Kawamura T, et al, for the Great Cold Investigators-I. Prevention of upper respiratory tract infections by gargling. A randomized trial. *Am J Prev Med.* 2005;29:302-307.

Synopsis Regular gargling with water or povidone-iodine solution may remove nasal-pharyngeal acquired viruses before they result in a URTI. The investigators randomized (allocation assignment concealed) 387 adults, aged 18 to 65 years, to gargling with water, gargling with povidone-iodine, or usual care. Subjects in the first two groups gargled with approximately 20 mL of water or povidone-iodine for approximately 15 seconds 3 times consecutively, at least 3 times daily. Follow-up occurred for 60 days, from December 2002 to March 2003, for 99% of subjects. Outcomes were reported by individuals (the study subjects) not blinded to treatment group assignment. Using intention-to-treat analysis, 130 subjects (34%) acquired a URTI, including 50 in the control group, 34 in the water group, and 46 in the povidone-iodine group. Only the difference between the water group and usual care group was significant (number needed to treat=9 for 60 days).

Dyspepsia management guideline (ACG)

Clinical question What is the best approach to managing dyspepsia?

Bottom line This evidence-based guideline (see synopsis) summarizes the best approach to the evaluation and treatment of patients with dyspepsia, defined as chronic or recurrent pain in the upper abdomen. (Level of evidence = 1a)

Talley NJ, Vakili N, for the Practice Parameters Committee of the American College of Gastroenterology. Guidelines for the management of dyspepsia. *Am J Gastroenterol.* 2005;10:2324-2337.

Synopsis Patients with dyspepsia may have gastroesophageal reflux disease (GERD), peptic ulcer, functional (nonulcer) dyspepsia, or, rarely, malignancy. The authors reviewed the world's literature and based their recommendations on the results of the best available evidence. Patients with onset of dyspepsia at age 56 or older or those with alarm symptoms (bleeding, anemia, early satiety, unexplained weight loss, dysphagia or odynophagia, persistent vomiting, family history of gastrointestinal malignancy, previously documented peptic ulcer, abdominal mass, or lymphadenopathy) at any age should undergo immediate upper endoscopy. Patients with reflux-predominant symptoms should be treated as if they have GERD. If the prevalence of *Helicobacter pylori* (HP) infection in the community is less than 10%, a trial of a proton pump inhibitor (PPI) is recommended. If that fails, a test for HP infection followed by eradication if positive should be pursued. Where HP is more common, the test-and-treat strategy should be pursued first, followed by a trial of a PPI. If these strategies fail, upper endoscopy should be considered according to the clinician's judgment. However, the prevalence of ulcer or malignancy in HP-negative patients is quite low.

Levels of evidence are explained at <http://www.infopeoms.com/levels.html>.
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