



Can Ginkgo prevent cognitive decline in older adults?

Ginkgo biloba is marketed widely in the USA and elsewhere and used with the hope of improving, preventing, or delaying cognitive impairment associated with aging and neurodegenerative disorders such as Alzheimer disease.

Previous controlled trials have found Ginkgo to be ineffective in the prevention of, or deterioration of, cognitive decline in subjects with Alzheimer disease. This study randomised 3069 elderly (72–96 years) subjects with normal cognition to 120mg of Ginkgo twice daily or placebo. After a median follow-up of 6.1 years it was concluded that Ginkgo did not result in less cognitive decline.

JAMA 2009;302(24):2663–70.

Total health care expenditure as percentage of GDP (gross domestic product) in the Czech Republic—a comparison with the rest of us

This commentary discusses a paradox that exists—Czech health statistics are comparable with other developed countries but their GDP% spent on health is the lowest—6.8% in 2006. In the same year, other European countries had figures ranging from 8.5% for the UK to 11% for France. You will not be surprised to find that the comparable figure for the USA was about 15.5%. So the Czech system, which features fees per service (doctor visit, prescription, and day fees for hospitalisation) may, or may not, be worth considering. The 6.8% of GDP spent on health in the Czech Republic is low, but not as low as the NZ figure—recently reported as 6.3% (public expenditure).

Lancet 2010;375:179–81.

Postoperative risk of venous thromboembolism in middle-aged women (50–64 years)

This study involved 947,454 middle-aged women in the UK who were involved in the Million Women Study between 1996 and 2001. During follow-up, 239,614 were admitted to hospital for inpatient or day case surgery; as well, 5689 women were admitted to hospital or died from venous thromboembolism. The findings were that those having surgery were 70 times more likely to suffer thromboembolism. The risk peaked at 3 weeks postoperatively but was still substantial at 12 weeks. Somewhat as expected but the 12-week observation is disconcerting. The risks varied substantially by type of surgery, being greatest after operations for cancer and for hip or knee replacement. Unfortunately data on postoperative thromboembolic prophylaxis was not available. This would have been very useful. Anyway, the message would appear to be that in high-risk cases prophylaxis should be given for 12 weeks? We assume that middle-aged men would be similarly affected?

BMJ 2010;340:32.

A nurse-led anterior circulation TIA clinic

This report from St Mary's Hospital in London points out that an estimated 23% of ischaemic strokes are preceded by a transient ischaemic attack (TIA), with the cumulative risk of stroke after TIA from the Oxford series being 8% at 7 days, 11.5% at 30 days, and 17.3% at 90 days. As stroke prevention is the aim, early evaluation of such patients is essential. The numbers are overwhelming the ability of the UK neurology services to see such patients urgently. Hence this initiative—specially trained neurovascular specialist nurses run what is called the FAST (face, arm, speech test) TIA clinic at St Mary's.

The acronym is in recognition of the clinical presentation of most anterior circulation TIAs. After 3 years experience (282 patients) they report a high pick-up rate of 86% of neurovascular events (national average about 55%). The median time from referral to clinic was 3 days and one-third were seen within 24 hours. Sounds good.

Postgrad Med J 2009;85:637–42.

Angiotensin-converting enzyme inhibitors (ACEI) or angiotensin II-receptor blockers (ARB), or both, for ischaemic heart disease

Both classes of drugs are known to have established benefit in patients with heart failure and those who have had a myocardial infarction with ventricular dysfunction. Their use, however, in patients with preserved ventricular function is less certain.

This paper attempts to resolve this by a systematic review of 41 relevant studies. The conclusion was that adding ACE inhibitor to standard medical therapy improves outcomes, including reduced risk for mortality and myocardial infarctions (relative risks 0.87 and 0.83 respectively) in patients with ischaemic heart disease with preserved ventricular function. Less evidence supports a benefit of ARB therapy, and combination therapy seems no better than ACE inhibitor therapy alone and increases harms. In particular, treatment withdrawal from combined therapy because of hypotension and syncope.

Ann Intern Med 2009;151:861–71.