

The short summaries in this digest are all taken from the Cochrane Library. Access to the Cochrane Library is free of charge in the UK and a number of other countries. Special schemes provide free access in Latin America and the Caribbean and in low-income countries (for details, see [www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME](http://www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME)).

## Flight socks and DVT

**Clarke M, Hopewell S, Juszczak E, Eisinga A, Kjeldstrøm M.** Compression stockings for preventing deep vein thrombosis in airline passengers. *Cochrane Database of Systematic Reviews 2006; issue 2*

This review considered whether the wearing of compression stockings (flight socks) reduced the risk of deep vein thrombosis (DVT) and other circulatory problems in airline passengers. The conclusions were based on nine trials which included over 2800 people, about half of whom were randomly assigned to wearing stockings for a flight lasting at least 7 h.

The stockings worn throughout the flight are similar to those known to be effective in patients lying in bed after an operation. Wearing compression stockings resulted in a very large reduction in symptomless DVT in the airline passengers who were allocated to wear compression stockings, compared with those who did not wear such stockings. People who wore stockings also had much less discomfort and swelling in their legs (oedema) than those who did not wear them.

Groups of airline passengers similar to those participating in the trials in this review can expect a substantial reduction in their risk of a symptomless DVT if they wear compression stockings. Wearing stockings might reduce the incidence of this outcome from a few tens per thousand passengers to two or three per thousand. Passengers who wear stockings will also experience less oedema in their legs. This review is unable to identify, however, whether these positive effects of wearing stockings translate into effects on outcomes such as death, pulmonary embolus and symptomatic DVT.

## Music for pain relief

**Cepeda MS, Carr DB, Lau J, Alvarez H.** Music for pain relief. *Cochrane Database of Systematic Reviews 2006; issue 2*

This review evaluated the effect of music, in children and adults, on acute, chronic, neuropathic or cancer pain or experimental pain. It included 51 studies, involving 3663 subjects, and found that music reduced pain, increased the number of patients who reported at least 50% pain relief, and reduced requirements for morphine-like analgesics. Listening to music for treatment of pain offers potential advantages of low cost, ease of provision and safety. As the magnitude of these positive effects is small, however, the clinical relevance of music for pain relief in clinical practice is unclear: music therefore should not be considered a first-line treatment for pain relief.

## Speed traps and road traffic injuries

**Wilson C, Willis C, Hendrikz JK, Bellamy N.** Speed enforcement detection devices for preventing road traffic injuries. *Cochrane Database of Systematic Reviews 2006; issue 2*

It is estimated that, by 2020, road traffic crashes will have moved from ninth to third in the world ranking of burden of disease, as measured in disability-adjusted life years. The identification of effective strategies for the prevention of road traffic injuries is of global public health importance. Measures aimed at reducing traffic speed are considered essential to preventing road injuries: the use of speed enforcement detection devices (SED; including speed cameras and radar and laser devices) is one such measure.

This review considered randomised controlled trials and controlled before–after studies that assessed the impact of SED on speeding, road crashes, injuries and deaths. Twenty-six studies met the inclusion criteria, the majority of which (22) were controlled before–after trials, the remainder being interrupted time-series designs with a comparison group(s). No randomised controlled trials were identified.

Despite the methodological limitations of the studies reviewed, the consistency of reported positive reductions in speed and crash outcomes across all studies suggests that SED are a promising intervention for reducing the number of road traffic injuries and deaths. More studies of a scientifically rigorous nature are still necessary, however, to provide a stronger evidence-base that these interventions are worthwhile. There is a need for international harmonisation of data-collection methods, including standards on how best to measure speeds and collect crash data over lengthy intervention and follow-up periods, as well as some consensus as to the expression of outcomes.

## Eye patches following corneal abrasion

**Turner A, Rabiou M.** Patching of corneal abrasion. *Cochrane Database of Systematic Reviews 2006; issue 2*

Corneal abrasion is a common presenting eye complaint and a potential risk for dentists and patients when protective eyewear is not worn. This review was conducted to determine the effects of eye patches, often recommended for treating corneal abrasions despite the lack of evidence for their use.

Eleven trials, which randomised a total of 1014 participants, were included in the review. A meta-analysis of seven studies favoured no patching on the first day of healing, whereas for days 2 and 3 there was no significant difference between the two groups. Of the nine trials that measured pain scores, two favoured no patching and none favoured

patching. Complication rates were low and no differences were noted in these between the two groups. No-patch groups generally received more adjuvant treatment with antibiotics and/ or cycloplegics than the patch group, which is an important confounding factor.

The authors concluded that treating simple corneal abrasions with a patch does not improve healing rates on the first day post-injury and does not reduce pain. In addition, use of patches resulted in a loss of binocular vision. Therefore it is recommended that patches should not be used for simple corneal abrasions. Further research should focus on large (greater than 10 mm<sup>2</sup>) abrasions.

---

## Preoperative hair removal and surgical site infection

---

**Tanner J, Woodings D, Moncaster K.**

**Preoperative hair removal to reduce surgical site infection. Cochrane Database of Systematic Reviews 2006; issue 2**

---

Preparation for surgery has traditionally included the routine removal of body hair from the intended surgical wound site. There are studies, however, that claim that pre-operative hair removal is deleterious to patients, perhaps by causing surgical site infections (SSI), and should not be carried out.

The primary objective of this review was to determine if routine pre-operative hair removal results in fewer SSI than not removing hair. Eleven

randomised controlled trials were included, comparing hair removal with no hair removal, different methods of hair removal, hair removal conducted at different times prior to surgery and hair removal carried out in different settings.

Three trials (including 625 people) compared hair removal using either depilatory cream or razors with no hair removal. These found no statistically significant difference between the groups in terms of SSI.

No trials were identified that compared clipping with no hair removal. Three trials, involving 3193 people, compared shaving with clipping and found that there were statistically significantly more SSI when people were shaved rather than clipped.

Seven trials (1420 people) compared shaving with removing hair using a depilatory cream but found no statistically significant difference between the two groups in SSI rates. No trials were identified that compared clipping with a depilatory cream. One trial (537 people) compared shaving on the day of surgery with shaving the day before surgery and one trial compared clipping on the day of surgery with clipping the day before surgery; neither trial found a statistically significant difference in the number of SSI. No trials were found that compared depilatory cream at different times or that compared hair removal in different settings.

The review found no difference in SSI in trial subjects who had hair removed prior to surgery and those who had not. If it is necessary to remove hair, clipping results in fewer SSI than shaving using a razor. There is insufficient evidence regarding use of depilatory cream compared with shaving using a razor. There is no difference in SSI when patients are shaved or clipped 1 day before surgery or on the day of surgery.

*Evidence-Based Dentistry* (2006) **7**, 53-54. doi:10.1038/sj.ebd.6400389