
These short summaries are taken from a range of other evidence-based journals and publications

Bicycle helmets prevented head and serious facial injuries

Evidence-based Health Policy and Management 1997 Vol. 1, p 10

Thompson D C, Nunn M E, Thompson R S, Rivara F P. Effectiveness of bicycle safety helmets in preventing serious facial injury. *JAMA* 1996; **276**: 1974–1975. Thompson D C, Rivara F P, Nunn M E, Thompson R S. Effectiveness of bicycle safety helmets in preventing head injuries. *JAMA* 1996; **276**: 1968–1973.

This paper summarises two case-controlled studies from Seattle in the USA. One compared serious facial injuries to a control group with injuries other than facial. The other compares all cyclists treated for head injury with non head-injured cyclists.

They found that helmets reduced the risk of upper face injury (odds ratio 0.36; 95% CI 0.26–0.49) and middle face (odds ratio 0.35; CI 0.24–0.5). They had no significant effect on lower face injury. Helmets gave a protective effect of 69–74% for three different categories of head injury. There were no significant differences with the different types of helmet used.

Evidence that helmets reduce head and upper face injuries is overwhelming. Dentists can do much to help public health professionals raise awareness of this issue and promote the wearing of helmets.

Anticonvulsant drugs reduce pain in trigeminal neuralgia and diabetic neuropathy and are effective for migraine prophylaxis

Evidence-based Medicine March/April 1996

Mcquay H, Carroll D, Jadd A R, Wiffen P, Moore A. Anticonvulsant drugs for the management of pain: A systematic review. *BMJ* 1995; Oct 21; **311**: 1047–1052.

Pain is a major clinical challenge in the 90s and is often managed inappropriately. This extensive systematic review of the use of anticonvulsant drugs was undertaken by the Pain Relief Unit in Oxford. Of the 37 studies identified only 20 met the criteria.

For trigeminal neuralgia there was an absolute risk reduction

of 38% (i.e. you would need to treat three patients for 5–14 days to provide pain relief for one). The authors concluded that anticonvulsant drugs were effective but were associated with adverse effects. However there was a high rate of non-response to carbamazepine (43%), and a lack of standardised reporting. The review better defines the role of anticonvulsants in the treatment of neuropathic pain and shows that there is much more to be done in this field.

Oral aciclovir shortened duration of symptoms in herpetic gingivostomatitis

Evidence-based Medicine January/February 1998

Amir J, Harel L, Sementa Z, Varsano I. Treatment of Herpes simplex gingivostomatitis with aciclovir in children: a randomised double blind placebo controlled study. *BMJ* 1997; Jun 21 **314**: 1800–1803.

This trial involving 72 Israeli children aged 1–6 years showed a 7-day course of oral aciclovir reduced the duration of oral lesions, fever, drooling and eating and drinking problems by 43–67%. The treatment was started up to 72 hours after onset. However the five times a day regime may make compliance difficult.

Amoxicillin did not improve the clinical course of acute maxillary sinusitis in primary care

Evidence-based Medicine September/October 1997

Van Buchem F L, Knottnerus J A, Schrijnemaekers V J, Peeters M F. Primary-care-based randomised placebo-controlled trial of antibiotic treatment in acute maxillary sinusitis. *Lancet* 1997; Mar 8 **349**: 683–687.

This study involved 214 patients in the Netherlands with suspected acute maxillary sinusitis. Patients had sinus radiographs taken and were allocated to amoxicillin or placebo. The study concluded that amoxicillin did not improve the clinical course. This conflicts with a previous study by Lindbaek *et al.* (*BMJ* 1996; **313**: 325–329). However both studies show placebo responses greater than 50% so until we can distinguish those benefiting from decongestants alone we should prescribe decongestant and weigh the slight-to-moderate antibiotic benefit against the risk of gastro-intestinal side-effects.