Use 4% dimeticone for head lice

REED & CARRICK/CDC

Dimeticone 4% lotion seems to cure head louse infestation as well as phenothrin 0.5% liquid, but it causes significantly fewer irritant reactions and has a physical action on lice that should not be affected by resistance to neurotoxic insecticides. In a randomised controlled equivalence trial that included 253 people with head lice, Burgess and colleagues (p 1423) compared the efficacy and safety of dimeticone lotion and phenothrin liquid. Irritant reactions occurred in 2% of the people treated with dimeticone and 9% of those treated with phenothrin.

POEM*

Milk intake correlates with increased risk of acne in women

Question Does milk intake increase the risk of teenage acne?

Synopsis Most, if not all, teenagers are concerned about acne and what they can do to prevent or minimise it. These investigators analysed data from the nurses health study, a prospective cohort study of 47 355 US nurses with greater than 90% follow-up. Participants with self reported "severe" acne (approximately 40% of the cohort) filled out a survey evaluating their food consumption between the ages of 13 and 18. The diet questionnaire was validated in a small subcohort of subjects, but most participants completed it after more than nine years had passed. Intake of whole milk and skim milk intake was significantly associated with an increased risk of acne. The odds ratios ranged from 1.16 to 1.44. There was no significant correlation with soda, french fries, pizza, or chocolate candy. Skim milk intake was more strongly associated with an increased risk of acne than whole milk. The authors report only the body mass index and onset age of menses for the subjects; no other demographics are noted (eg, race, birth control usage). Possible reasons for the association include the potential of hormones being in the milk, and whey proteins. It is uncertain if soy milk or hormone-free milks would produce different results.

Bottom line Whole milk and skim milk intake are associated with a slightly increased risk of teenage acne. This study design cannot prove causation, and we have no evidence that decreasing intake will improve acne. It is important that teenage women have an adequate intake of calcium and vitamin D to help bone growth and formation. Although a number of non-dairy products with added calcium have been introduced, we should not recommend decreasing the intake of dairy products to reduce the risk or severity of acne until we have better evidence.

Level of evidence 2b (see www.infopoems.com/levels.html). Individual cohort study or low quality randomised controlled trials (<80% follow-up)

Adebamowo CA, Spiegelman D, Danby FW, Frazier AL, Willett WC, Holmes MD. High school dietary dairy intake and teenage acne. *J Am Acad Dermatol* 2005;52:207-14.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

Make up your own minds

Hands up if you are over 50 and take an aspirin a day, or if you advise your older patients and friends to do this. It may seem a harmless and effective precaution against potentially devastating vascular events. But do the benefits outweigh the risks? Should it be offered as primary prevention to everyone over 50, or just to those at increased risk?

This week, two commentators explore the evidence for and against aspirin for everyone over 50 (pp 1440, 1442). In favour of such a policy, Peter Elwood and colleagues argue that about 80% of men and 50% of women in the United Kingdom aged 50 or older are already deemed to be at increased risk—defined as being at a 3% or greater risk of having a vascular event (myocardial infarction or stroke) in the next five years. Current practice is to target these people for primary prevention, but efforts to identify and engage them have proved unsuccessful. Elwood also argues that the risks of serious harm from low dose aspirin in people without contraindications are small, and the benefits include, as well as protection from vascular events, the possibility (not yet proved in randomised controlled trials) of protection against cancer and dementia.

Against this, Colin Baigent says that the expected benefits among unselected people younger than 60 do not exceed the expected risk of major gastrointestinal bleed, while for older people the benefits are uncertain and the risks too high. We should, he says, await the results of further large randomised controlled trials before putting people unnecessarily at risk.

How much of this decision can be handed over to patients? All of it, argues Elwood. Doctors, he says, should not be asked to predict the risk of bleeding in people who don't have obvious contraindications. Faced with such a request from patients, they will tend to advise against treatment as being the safest option in terms of liability. "The general public should be well informed and the final decision should lie with each person."

But as this *BMJ* debate shows, the evidence on the risks is complex and open to interpretation. Is it sufficient simply to add up the expected number of vascular events and major bleeds when such events are likely to impact differently on people's lives? I'm afraid that, like your patients, you will have to make up your own minds.

We can, however, give you definitive news on another approach to primary prevention—the polymeal. Last Christmas, Franco and colleagues presented an evidence based menu that they estimated could reduce cardiovascular disease by more than 75% (*BMJ* 2004;329:1447-50). A *BMJ* competition to find the best recipe for such a polymeal has now, with the help of celebrity chef Raymond Blanc, come up with a winner. The winning recipe, including all the necessary elements of wine, fish, dark chocolate, fruits, vegetables, garlic, and almonds, is published this week (p 1422). We will be asking our editorial board, some of whom are over 50, to sample it. Randomised trials will follow.

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