Clinical shorts

Family history for cardiovascular risk assessment: Systematically collecting information about family history increases the proportion of people identified as having high cardiovascular risk, which provides an opportunity for targeted prevention. A matched-pair, cluster-randomized controlled trial included 748 adults with no previously diagnosed cardiovascular risk in 24 family practices. All patients received a cardiovascular risk assessment by their family physician; those in the intervention practices also received a family health questionnaire. Over 98% of participants in the intervention group completed the questionnaire. The mean increase in the proportion of participants classified as high cardiovascular risk (10-year risk ≥ 20%) was 4.8% in the intervention practices after family history from the questionnaire was incorporated into the risk assessment, compared with 0.3% in the control practices using family history extracted from electronic health records (difference between groups 4.5 percentage points, 95% confidence interval 1.7 to 7.2). See *Ann Intern Med* 2012;156:253-62.

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Nicotine-replacement patches in pregnancy: Adding a nicotine patch to behavioural cessation support did not increase the rate of abstinence from smoking or the risk of adverse pregnancy or birth outcomes in women who smoked during pregnancy. This is the conclusion of a randomized controlled trial that included 1050 pregnant women (at 12 to 24 weeks' gestation) who smoked at least five cigarettes per day. Participants were randomly assigned to receive nicotine-replacement therapy (transdermal patch) or placebo for eight weeks. All received behavioural cessation support. Abstinence was determined by self-report and validated with salivary cotinine or exhaled carbon monoxide measurement at delivery. There was no significant difference in the rate of abstinence from quit date to delivery between the two groups (9.4% in the treatment group v. 7.6% in the control group; unadjusted odds ratio with treatment 1.26, 95% confidence interval 0.82 to 1.96). Compliance was very low; only 7.2% in the nicotine-replacement group continued for more than one month, compared with 2.8% in the placebo group. Rates of adverse pregnancy and birth outcomes were similar in both groups. See *N Engl J Med* 2012;366:808-18.

Age and sex differences in mortality and presenting symptoms of myocardial infarction: Women with myocardial infarction are more likely to present without chest pain or discomfort and have higher mortality than men in the same age group, but sex differences attenuate with increasing age. Using data from a US national registry, an observational study included more than 1.1 million patients admitted to hospital with confirmed myocardial infarction over a 12-year period. Although the proportion of patients without chest pain was significantly higher for women than men (42.0% v. 30.7%, $p < 0.001$), this difference attenuated with increasing age. For women aged 45 to 54 years (compared to men), the adjusted odds ratio (OR) for lack of chest pain was 1.26 (95% confidence interval [CI] 1.22 to 1.30); by ages 65 to 74 years, this ratio had dropped to 1.13 (95% CI 1.11 to 1.15). Although younger women had greater hospital mortality than younger men (OR 45 to 54 years 1.13, 95% CI 1.02 to 1.26), the difference decreased or even reversed with advancing age. Patients without chest pain were less likely to receive timely acute reperfusion therapies and medications, such as aspirin, other antiplatelet agents and β-blockers during hospitalization. The absence of chest pain was associated with increased mortality, which may explain in part the excess risk of death in younger women. See *JAMA* 2012; 307:813-22.

Internet-based treatment for teens with chronic fatigue syndrome: An Internet-based therapeutic program was highly effective in teens with chronic fatigue syndrome. In a randomized controlled trial, 135 adolescents with chronic fatigue syndrome were assigned to receive an Internet-based psychoeducational and cognitive behaviour therapy program that included e-consults with psychotherapists or usual care (e.g., individual- or group-based rehabilitation programs, face-to-face cognitive behavioural therapy or graded exercise treatment). At six months, those in the treatment group were more likely to have full school attendance (relative risk [RR] 4.8, 95% confidence interval [CI] 2.7 to 8.9), absence of severe fatigue (RR 3.2, 95% CI 2.1 to 4.9) and normal physical functioning (RR 3.8, 95% CI 2.3 to 6.3). The number needed to treat to achieve recovery for these combined outcomes was 1.8. See *Lancet* 2012; doi:10.1016/S0140-6736(12)60025-7.

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