match the presenting symptoms in a patient. Concurrent ther-
apies were used by 60% of homeopaths.

Counselling (either by the practitioner or via a referral) was utilised for 76% of the average caseload, and was the most common concurrent therapy after conventional medication use (which occurred in 80% of the caseload). Psychotherapy was the next most common concurrent treatment, followed by vitamin therapy (63%) and herbal medicine (50%).

This multidisciplinary approach was also evident in many of the comments made by the practitioners. For example, that homeopathy only works well for depression when the correct constitutional remedy for the patient is identified; homeopathy is excellent for the treatment of depression when there is concurrent use of counselling techniques; lifestyle and nutrition aspects are important as depressed people rarely look after themselves well, and the most severely depressed patients do not respond well to homeopathy.

The researchers noted that a limitation of their study was that practitioners were unable to use actual case files. For future research, the researchers suggested that a case study approach would allow for more complete data to be obtained.

**MASSAGE RELIEVES NAUSEA IN WOMEN UNDERGOING CHEMOTHERAPY**


This Swedish randomised controlled trial examined the effects of massage on women undergoing chemotherapy for breast cancer. In particular, the study looked at the effects a series of 20 minute massages might have on the nausea, anxiety and depression being experienced by the women.

Thirty-nine women, mean age 51.8 years, took part in the trial, with 19 randomly assigned to the massage group and 20 randomly assigned to the control group. The women in the massage group were offered a 20 minute massage, consisting of effleurage strokes, to either their foot/lower leg or to their hand/lower arm. All except 3 chose the foot/lower leg massage.

The massages were performed by nurses or nurses’ aids who had received a 1 day training session and who were said to be experienced in massaging patients with cancer. The massages occurred while the women were undergoing chemotherapy infusion. A cold pressed vegetable oil was used. The massaged limb was wrapped in a towel immediately after the massage. Five massage sessions were conducted. The control group did not receive any massage. They were visited by a hospital staff member, and had an unstruc-
tured conversation for 20 minutes.

The main finding was that massage significantly reduced nausea in the massage group compared to the control group. Although the mechanism for this result is not known, it was thought that the effect was partly due to massage releasing hormones such as oxytocin.

Oxytocin has been shown to have an anxiolytic effect, resulting in relaxation and decreased nausea. Contrary to other studies, the massage did not reduce anxiety. It was thought that this might be due to this study group having relatively low base line levels of anxiety, and thus leaving little room for improvement. Massage also did not have any effect on depression.

**FOLIC ACID REDUCES FIRST STROKE RISK**


Homocysteine has long been suspected as being linked to the atherosclerotic process, which in turn is well known to be implicated in cardiovascular disease. Although folic acid is known to lower homocysteine concentrations, studies which have looked at the association of homocysteine and cardiovascular disease have produced inconsistent results.

The authors of this meta-analysis postulated that folic acid supplementation might have a greater protective effect in primary rather than secondary prevention of cardiovascular disease complications. Also, given that cardiovascular disease is a broad endpoint covering several clinical entities, it is possible that specific clinical entities might respond differently to folic acid supplementation. This factor might also account for the inconsistent results published to date.

Accordingly, the authors conducted a meta-analysis of randomised controlled trials involving folic acid intervention and which included stroke as an identified end point. Additionally, the trials needed to record the number of strokes for both the intervention and control groups, and the folic acid intervention, with or without additional B vitamin supplementation, had to be for at least 6 months.

Eight trials were identified as meeting these prerequisites. The trials had between 88 to 5,522 participants, the total number of participants being 16,841. Folic acid supplementation dosage ranged between 0.5 mg/d to 15 mg/d, while the duration of the folic acid intervention was between 24 to 72 months. All the participants had pre-existing conditions, including one trial where the participants had a history of stroke.

The pooled results of all 8 trials showed that folic acid supple-
mentation, with or without additional B vitamin supplement-
ation, significantly reduced the relative risk of stroke by 25% in participants who did not have a history of stroke. However, no additional benefits from folic acid supplementation were shown in subjects who had already experienced a stroke.

The duration of the intervention also seemed important. The relative risk of stroke where the intervention was 36 months or less was not improved by folic acid supplementation. Trials with a duration longer than 36 months however showed a 29% reduction in the relative risk of stroke.

There were considerable differences in the net and relative reductions in homocysteine concentrations. Nevertheless, there seemed to be an inverse relation between the degree of