magnetic resonance imaging (MRI) scan revealed three ring-enhancing lesions less than 1 cm in diameter, suggestive of neurocysticercosis. He was treated with phenytoin and also received dexamethasone for 1 month. A repeat MRI scan 6 months later showed significant reduction in the size of the lesions, to less than 3 mm. Phenytoin therapy was ceased after 3 months, with no seizures at last review (6 months). In view of the temporal association between the treatment and the seizures in this previously asymptomatic patient, we believe the seizures were precipitated by the praziquantel therapy.

Cysticercosis, which is endemic across the developing world, is caused by the helminth Taenia solium. Clinical disease, including neurocysticercosis, is often asymptomatic. Symptomatic neurocysticercosis often presents as seizures, especially as the cysts degenerate, and is the commonest cause of acquired, late-onset epilepsy in the developing world.¹ The benefit of treatment remains controversial, especially when there are only a few cysts.¹-³ Praziquantel and albendazole therapy accelerate cyst degeneration, and subsequent inflammation may precipitate seizures, which are sometimes pre-emptively managed with corticosteroids.¹ There is conflicting evidence on the benefit of treatment for long-term seizure frequency.²,³

Although screening for some parasitic infections in refugees in Australia is recommended,⁴ this does not include cysticercosis. Serological tests for T. solium cannot differentiate between active and past infections, have limited sensitivity, are not widely available in Australia, and cannot differentiate between neurocysticercosis and cysticercal disease elsewhere.³ The only reliable method for diagnosis is neuroimaging, which is impractical for mass screening.

Nevertheless, we advocate a high degree of suspicion for neurocysticercosis in migrants from Taenia-endemic areas. Geographical origin alone is insensitive for identifying an at-risk population. A history of seizures, or the presence of subcutaneous nodules, should prompt investigation with serological testing and subsequent neuroimaging before consideration of treatment. In such symptomatic patients, this will allow the need for anthelmintic therapy to be assessed, along with consideration of adjunctive corticosteroid therapy.

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What is the place of a student medical journal?
Matt D Schiller

TO THE EDITOR: “Student medical journals” are a very broad church, encompassing everything from pseudo-magazines to rigorously peer-reviewed publications. In April this year, a national journal of the latter variety was launched here in Australia: the Australian Medical Student Journal (AMSJ).¹

The AMSJ accepts research, review and opinion articles from students of medicine or health sciences at Australian universities. The journal’s volunteer staff comprises only medical students, and peer-review is by academics associated with Australian medical schools, or clinicians at Australian teaching hospitals. The inaugural issue could hardly have been more national in its focus, with students from 14 Australian medical schools, covering every state, being represented among the authors.

The issue was recently distributed free of charge to thousands of medical students around Australia in both print and electronic formats. After the success of the inaugural issue, we plan to begin biannual production from 2011, continuing in both formats. The AMSJ operates as a not-for-profit student organisation, and printing and other costs are provided for by sponsors, including the Australian Medical Association, Australian General Practice Training, and the Royal Australasian College of Physicians.

While it is unique in a number of facets, the AMSJ is not the first publication of its kind. The Australian Medical Students’ Association magazine Panacea began life in 1968 as a journal, albeit not peer-reviewed.² Several individual Australian medical schools have had their own academic publications for varying periods, such as the Sydney University Medical Journal, which was first published around 1905.³ More recently, our counterparts across the Tasman were well ahead of us, with the New Zealand Medical Student Journal releasing its first issue in 2004.⁴ Further afield, some of the better known student journals are the McGill Journal of Medicine (MJM) in Canada and the Student BMJ in the United Kingdom.

Most student journals fall roughly into one of two categories: those whose focus is primarily instruction and entertainment, with shorter educational or blog-style articles (often written by non-students) having appeal to time-constrained students (eg, Student BMJ); and those that publish academically rigorous student work, perhaps at the expense of reader interest (eg, MJM). The AMSJ has a number of aims (Box), although central to our mission is to transcend this artificial tension and attract student-authored articles that are both thoroughly interesting and academically substantial. The rationale is that anything short of a

Aims of the Australian Medical Student Journal⁵

To provide a medium for Australian medical students to publish their work and share ideas with their peers.
To provide a suitable forum for students to make the transition between assignment writing and producing publishable academic work.
To inform students about medical topics and issues not typically addressed in core curricula.
To facilitate discussion of current issues relevant to medical students.
To allow Australian medical schools to showcase the research aspects of their programs.
To provide a further incentive for students to produce high-quality work in their studies.
To foster the next generation of Australian medical researchers and physician-scientists.
To provide an avenue for students interested in a career in medical editing or publishing to pursue this interest as a student staff member.
A proper peer-reviewed journal is patronising towards students, but, on the other hand, articles that are not appropriately pitched cause disenchantment.

Medical students have played key roles in the history of medicine: notable discoveries made or shared in by medical students include heparin, insulin, the sinoatrial node, the pancreatobiliary sphincter, ether anaesthesia, islets of Langerhans, and spermatozoa. We hope that the AMSJ can continue to promote and foster this tradition of student achievement.

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Correction
Incorrect statement of risk: In “Factors associated with psychiatric morbidity and hazardous alcohol use in Australian doctors” in the 2 August 2010 issue of the Journal (Med J Aust 2010; 193: 161-166), there was an error in the last paragraph of the Results section (page 163). The wording of the last sentence of the paragraph should be: “Doctors were at less risk of hazardous alcohol use if they: trained overseas rather than in Australia (OR, 0.56 [95% CI, 0.39–0.81]); worked more than 60 hours a week compared with less than 40 hours a week (OR, 0.67 [95% CI, 0.45–0.99]); and had not taken a holiday in more than a year (OR, 0.63 [95% CI, 0.43–0.93]).”