Consultant's Corner

Answers to your questions from medical experts

1. Can botulinum toxin A beat migraines?

Do botulinum toxin A injections have a role to play in the management of migraines?

Question submitted by
Stephen Coyle, MD
Winnipeg, Manitoba

Up to 75% of migraine sufferers benefit from treatment with botulinum toxin A, meaning they either have fewer migraines, or use less medication.

While only 25% of migraine sufferers remain completely migraine-free for months at a time, the benefits are usually worthwhile for those who do respond.

Migraine sufferers will benefit from injections in the frontal area and also in any trigger points, such as the temple and occipital areas.

Migraines should be diagnosed by a neurologist prior to botulinum toxin A therapy.

Answered by:
Alastair Carruthers, BM, BCh, MA, FRCPC
Clinical professor,
Division of dermatology,
University of British Columbia,
Vancouver, British Columbia

This month:

2. At risk of cancer?

If a woman is taking enough phytoestrogens (soy or black cohosh), could the unopposed estrogens be enough to put her at risk for endometrial hyperplasia or carcinoma?

Question submitted by
Suzanne Gossier, MD
Westbank, British Columbia

The development of endometrial cancer is thought to be related to prolonged exposure to unopposed estrogens.[1]

Phytoestrogens, of which isoflavones and lignans are the most commonly used by post-menopausal women, may have antiestrogenic effects.

Although unopposed estrogen replacement may promote breast and endometrial cancer, there is no evidence that phytoestrogens will do the same.[2] While no human research has been conducted, researchers have a strong belief in the cancer-protective effects of phytoestrogens.

One case-control study concluded that some phytoestrogenic compounds, used by women in a typical North American diet, are associated with a reduced risk of endometrial cancer.[3] Another randomized, controlled trial concluded that phytoestrogens did not cause stimulation of the endometrium.[4]

Although data regarding the use of phytoestrogens are incomplete, dietary supplementation with isoflavones and lignans appears to be a safe and possibly beneficial option for postmenopausal women.

References
1. North American Menopause Society: Treatment of menopause-associated vasomotor symptoms: Position statement of The North American Menopause Society. Menopause 2004; 11(1):11-33.
2. Carusi D: Phytoestrogens as hormone replacement therapy: An evidence-based approach. Prim. Care Update Ob Gyns 2000; 7(6):253-9.
3. Horn-Ross PL, John EM, Canchola AJ, et al: Phytoestrogen intake and endometrial cancer risk. J Natl Cancer Inst 2003; 95(15):1158-64.
4. Balk JL, Whiteside DA, Naus G, et al: A pilot study of the effects of phytoestrogen supplementation on postmenopausal endometrium. J Soc Gynecol Investig 2002; 9(4):238-42.

Answered by:
Lydia Hatcher, MD, CCFP, FCFP
Director,
Continuing Medical Education,
Memorial University,
St. John's, Newfoundland

3. What about that itchy fungus?

Steroid creams are often mixed with antifungals (*e.g.*, Lotriderm®). Is this a good or bad idea for an itchy fungus rash?

Question submitted by
Joseph Yang, MD
Surrey, British Columbia

The itching and irritation caused by fungal and yeast infections can be very bothersome. While adding a steroid to an antifungal can greatly hasten the relief in affected areas, the side-effects of steroids (*i.e.*, systemic absorption and atrophy of the skin) should always be considered.

For example, hydrocortisone mixed into an antifungal can be used for a short time for diaper rashes caused by candida. However, the occlusion of the diaper, the thin skin of an infant's groin, and moisture can increase steroid absorption greatly, therefore, flourinated steroids should be avoided.

While Lotriderm®, which contains betamethasone diproprionate, would not be appropriate for diaper rashes, it would be helpful for very itchy tinea pedis or tinea corporis.

In general, dermatologists use specific agents for identified problems—pure antifungals for diagnosed fungal infections. Combination agents to "cover the bases" often tend to be used when there is no clear diagnosis.

There is always the risk of unwanted side-effects from the inclusion of extra therapeutic agents that may not really be needed.

Answered by:
Scott Murray, MD, FRCPC
Associate professor,
Dalhousie University,
Halifax, Nova Scotia

4. Discovering gynecomastia

What is the approach to investigating gynecomastia in a healthy 50-year-old man who is feeling well?

Question submitted by
Dr. Heather Ostic, MD
Kingston, Ontario

Gynecomastia consists of subaeolar ductal tissue enlargement in a concentric ring > 2cm.

First, ensure that the condition is true gynecomastia (not fat) and it is not fixed to suggest any local invasive process.

Gynecomastia reflects a relative decrease in testosterone action and/or increase in estrogen action. Lower testosterone secretion may result from primary (testicular) or secondary (hypothalamus-pituitary) disease. If found, a serum luteinzing hormone (LH) separates these two sites, being elevated with primary testicular disease.

Hyperprolactinemia of any cause may give secondary testosterone deficiency. Drugs such as antiandrogens (*e.g.* spironolactone) block testosterone action at the breast.

Increased estrogenic action may result from:

- estrogenic agents in the workplace or medications,
- increased estrogen activity found in obesity,
- chronic hepatic failure or hyperthyroidism,
- testicular secretion (human chorionic gonadotropin [HCG] secreting tumors), or
- adrenal secretion (estrogen-secreting tumors).

I would perform liver function tests and measure:

- serum-free testosterone index (or bioavailable testosterone),
- serum LH,
- serum estradiol,
- serum or urine HCG,
- serum thyroid-stimulating hormone, and
- serum prolactin.

Because he is well, all normal tests would diagnose idiopathic gynecomastia, by exclusion, but followup is indicated. CME

Answered by:
Bernard Corenblum, MD
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University of Calgary,
Calgary, Alberta