You asked about...

Answers to your questions from medical experts

1. What's the family physician's role with their oncology patients?

Should family physicians be involved in the supportive care of patients admitted to the oncology unit?

What are the pros and cons of such an involvement?

Question submitted by
Jean-Yves Plourde, BSc, MSc
Cap-Pelé, New Brunswick

Continuity of primary care is known to be associated with improved processes and outcomes of care. Much of the research in this area has focused on the continuity of outpatient care in reducing emergency department visits among patients with cancer.

However, the question posed raises another issue: should primary care physicians remain involved in the care of cancer inpatients? The advantages of such an approach are numerous: Primary care physicians can offer the patient and family psychologic support and build strong lines of communication between patients and oncologists. As well, they can assist in the terminal stages of patient management.

The argument could also be made that discontinuing primary care continuity may result in miscommunications between patient, families, and physicians, inappropriate deferring of advanced care planning to the hospital setting, and lack of familiarity with a patient's symptom control.

Answered by:
Mohit Bhandari MD, FRCSC
Orthopadic Surgeon
McMaster University Health Sciences Centre
Hamilton, Ontario

This month:

1. What's the family physician's role with their oncology patients?
2. Can cholesterol absorption inhibitors lower lipids?
3. How are homocysteine levels lowered?
4. What's the first-line treatment for BPH?
5. What are the options for osteoporosis?

2. Can cholesterol absorption inhibitors lower lipids?

Can a cholesterol absorption inhibitor, such as ezetimibe, be used as a single lipid-lowering agent in patients who are allergic/intolerant to all fibrates/statins?

Question submitted by
Dr. Jack Kooy, MB, ChB
Penticton, British Columbia

Yes. Ezetimibe has not been shown to cross-react in patients intolerant of statins or fibrates. It is less potent than statins when used as monotherapy. A 10 mg daily dose significantly lowers low-density lipoprotein (LDL) cholesterol by about 18%, triglycerides by approximately 8%, and increases high-density lipoprotein (HDL) cholesterol by roughly 2%, as compared to placebo.[1]

It appears to be most useful in combination therapy with statins. Daily treatment with ezetimibe, 10 mg, plus the starting dose of a statin may result in LDL-cholesterol lowering up to the equivalent (but without the side-effects) of a full dose of statin. This may be a result of complementary actions (inhibition of cholesterol absorption and synthesis). In a patient who can only tolerate a low dose of a statin, further cholesterol lowering could be achieved with the addition of ezetimibe, possibly without much increase in the risk of side-effects.

Currently, there are no published studies linking ezetimibe use with cardiovascular event reduction, either as monotherapy or in combination therapy.

Answered by:
Dr. T.K. Lee, MSc, MB, BS, MRCP, ABIM, FRCPC
Clincial professor of medicine,
University of Alberta
Edmonton, Alberta

Reference
1. Medical Letter 2003; 45(1151):17-9

3 How are homocysteine levels lowered?

What would you prescribe for someone with elevated homocysteine levels?

Question submitted by
Pat Cunningham, MD
Brantford, Ontario

There is reasonably good evidence from population studies that elevated homocysteine levels are associated with an increased risk of cardiovascular disease. Several vitamins, including B12, B6, and folate, are involved in homocysteine metabolism and supplementation has also been shown to reduce homocysteine levels. Typical combinations include folate, 2 mg, B12, 500 mg, and B6, 100 mg, daily.

Although lowering homocysteine post-angioplasty reduced restenosis in one study, another trial demonstrated an increased restenosis rate. The Vitamin Intervention for Stroke Prevention trial demonstrated that lowering homocysteine in stroke survivors did not reduce the composite end point of stroke, coronary heart disease, or death. The Heart Outcomes Prevention Evaluation (HOPE) study investigators are conducting a large,prospectively randomized controlled trial to definitively answer the question about thebenefit of homocysteine treatment, but results will not be available for several years.

The American Heart Association, Canadian Cardiovascular Society and Interventional Task Force for the Prevention of CAD are waiting for results of large prospective trials before homocysteine is considered a treatable risk factor.

Answered by:
Dr. Ken Gin, FRCPC
Associate clinical professor,
Director, cardiology training program, University of British Columbia, and Assistant director, coronary care unit, Vancouver Hospital & Health Sciences Centre,Vancouver, British Columbia

4. What's the first-line treatment for BPH?

Since the Prostate Cancer Prevention Trial (PCPT) showed a 25% reduction in prostate cancer, shouldn't finasteride, not alphablockers, be first-line treatment for BPH?

Questions submitted by
Ed Whitten, MD
Cranbrook, British Columbia

The PCPT showed a reduction of prostate carcinoma (PCa) in men with elevated prostate specific antigen (PSA), a subset of patients with benign prostate hypertrophy (BPH).

Right now, we know that BPH is, in fact, two diseases in one and that men with very large glandular prostates are more likely to benefit from finasteride.

Men with the second type of BPH, which is more toxic, will benefit from an alphablocker. The delayed action of proscar on symptom and flow is between three to six months. While the argument could be made that both medications could be used in unison, it would double the cost.

Side-effects, such as the loss of libido, asthenia, and impotence, are of concern with finasteride.

I think there is a place for finasteride use, with or without alphablocker, in specific BPH conditions. However, I am not yet convinced that general use of the product is advised in all men with BPH.

Answerd by:

Paul Perrotte,
Assistant professor
Urology Department, CHUM
Montreal, Quebec

5. What are the options for osteoporosis?

Of the three, bisphosphonates, raloxifene, and calcitonin, which group or entity has the most compelling data for hip and spine prescription in osteoporosis?

Question submitted by
Stephen Coyle, MD, MBBS, LMCC, CMO
Winnipeg, Manitoba

The oral bisphosphonates, risedronate and alendronate, are effective in preventing vertebral and non-vertebral (hip) fractures in post-menopausal women with osteoporosis. Raloxifene, which is a selective estrogen receptor modulator, is effective in preventing vertebral fractures, however, there is no supportive data for its ability to prevent hip fractures.The use of calcitonin is less well established. CME

Answered by:
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