CONSULTANT'S CORNER

Practical answers to your everyday questions

1. Is ICS an option?

Can people with active tuberculosis and asthma use inhaled corticosteroids (ICS)?

Question submitted by
N.H. Duong, MD
Ottawa, Ontario

There are generally no contraindications to use inhaled gluco-corticosteroids in patients with active tuberculosis when an appropriate treatment is provided for this disease. As for any other situation, the dose of steroids should always be kept at the minimum required to keep asthma under control.

ICS should be avoided, or at least used with caution, in asthmatic patients who have drug-resistant tuberculosis or some degree of immunosupression. However, these are not absolute contraindications for the use of ICS.

Answered by:
Louis-Philippe Boulet, MD, FRCPC
Professor of medicine
Université Laval
Quebec City, Quebec

This month:

2. Is it hypogonadism?

If you suspect andropause and the testosterone levels are within normal limits, would you treat a 55-year-old man with supplemental testosterone?

Question submitted by
George Rosenkranz, MD
Ponoka, Alberta

The signs and symptoms of hypogonadism must be carefully evaluated. Decreased muscle mass, gonadal size, shaving frequency, osteoporosis, nocturnal erections, libido, and erectile dysfunction (ED) point to a testosterone deficiency. However, fatigue, weakness, and mood changes are non-specific.

Only 4% to 10% of men with ED have testosterone deficiency. In most patients, the deficiency results from drugs or neurovascular (*i.e.*, atherosclerotic disease, diabetes), or psychogenic causes.

It is important to consider the actual symptoms and precise testosterone level. If the testosterone level is definitely within normal range, search for other possible causes of symptoms; there is no place for a testosterone therapy trial.

Testosterone therapy causes a dose-related increase in muscle mass. Recent evidence also suggests men with borderline low testosterone levels get an increase in bone density with therapy. However, there is no evidence that other symptoms are improved by increasing testosterone levels above a low normal value.

The only time a trial of therapy may be considered is in patients with a borderline low total serum testosterone (10 mmol/L to 11 mmol/L) and specific signs/symptoms of hypogonadism.

Normal ranges, being statistically derived, have a builtin 5% error and, hence, low-end values may actually represent testosterone deficiency. In such cases, obtaining a bioavailable testosterone or free testosterone may help determine if the testosterone is truly normal or not.

If such a test is clearly normal, a trial of therapy is not warranted. If a trial is undertaken, hematocrit and prostatic function, as well as prostate-specific antigen must be monitored.

Answered by:
Donald Morrish, MD, PhD, FRCPC
Professor
University of Alberta
Edmonton, Alberta

3. Shedding light on eye patching

Once a diagnosis of corneal abrasion is made, what is the recommended action with regard to patching eyes?

Question submitted by
Alok Sood, MD
Toronto, Ontario

Eye patching is no longer recommended for most corneal abrasions. Patching, along with antibiotic ointment, is indicated for larger abrasions to reduce blinking and increase patient comfort, but should not be not done if vegetable matter or false fingernails are involved in the injury.

Patching does not appear to increase the rate of epithelial healing. Further, it is contraindicated in contact lens wearers due to an increased risk of infectious keratitis (most commonly from *Pseudomonas aeruginosa*).

Small, non-infected, non-contact lens-related traumatic corneal abrasions, as well as abrasions secondary to foreign body removal, may be treated with antibiotic agents and mydriatics alone.

Patients should be re-evaluated daily until the abrasion has healed. A referral to an ophthalmologist may be needed for non-healing abrasions or if keratitis is suspected.

Answered by:
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4. What about the continuous use of OCP?

Is it safe and effective to use the birth control pill continuously (without menstrual bleeding)?

Question submitted by
Chantal Saint-Dizier, MD
Repentigny, Quebec

There are no medical or physiologic reasons behind the traditional use of the oral contraceptive pill (OCP) on a 21-day on and seven-day off protocol.

The continuous use of the OCP is often associated with some breakthrough bleeding after a few months of continuous use. The pill can simply be continued during this bleeding or stopped for a week to allow the endometrium to shed. In my experience, stopping the OCP for a week every three or four months reduces breakthrough bleeding.

Monophasic pills with 30 mcg ethinyl estradiol (EE) are the best options, as they are associated with less breakthrough bleeding than triphasic or 20 mcg EE pills.

Answered by:
Paul Claman, MD, FRCSC
Professor
University of Ottawa
Ottawa, Ontario

5. Approaching bipolar depression

How is bipolar depression best managed?

Question submitted by
Diana Klijenak, MD
Toronto, Ontario

Bipolar depression is associated with greater morbidity, disability, economic burden, and suicide than mania. The recognition and treatment of this condition is, therefore, a matter of utmost importance.

The selection of treatment strategies depends on the type of bipolar depression (type I, depression with mania; type II, depression with hypomania), severity, and phase of the illness (acute, maintenance).

General principles of treatment are:

- use mood stabilizer in every phase and type of the illness;
- select mood stabilizers with proven efficacy on depression (*i.e.*, lithium, lamotrigine, olanzapine);
- use antidepressants with high potentials for manic induction (*i.e.*, tricyclics and monoamine oxidase inhibitors) cautiously;
- use mood stabilizers as monotherapy for mild to moderate bipolar I depression;
- avoid antidepressants in bipolar I maintenance, and;
- combined treatment may be necessary for acute, severe depression and for breakthrough depression during the maintenance phase. Commonly used combination treatments include:

  -selective serotonin reuptake inhibitor (SSRI) + atypical antipsychotics,

  -SSRI + lithium,

  -lithium + lamotrigine,

  -lamotrigine + atypical antipsychotics, and

  -lithium + atypical antipsychotics.

Please refer to the Canadian Treatment Guidelines for bipolar disorder regarding dosage and adverse effects of individual drugs.

Answered by:
Rajamannar Ramasubbu, MD, MSc, FRCPC
Assistant professor
Psychiatry and neurosciences
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Calgary, Alberta

6. When do I refer a fainting teenager?

Is there any type of fainting in teenagers that merits immediate referral to a cardiologist?

Question submitted by
Joel Kirsch, MD
Toronto, Ontario

Fainting in teenagers is very common and almost always related to vasovagal syncope.

Warning signs of concern when teenagers faint include a family history of sudden death or fainting during exercise. Both findings may not necessarily be malignant, but suggest the possibility of underlying structural heart disease or a propensity to malignant arrhythmias. CME

Answered by:
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