Steroids for dermatosis?

1.

Given that steroids should be avoided, how can facial dermatosis be best managed?

Question submitted by:
Dr. Colleen Webster
Kingston, Ontario

The primary type of facial dermatosis should be clarified. Rosacea and perioral dermatitis are best managed with good basic skin care and oral or topical antibiotics. Contact dermatitis (both irritant and allergic) requires careful history-taking and avoidance of triggering factors. Atopic or endogenous dermatitis requires adequate moisturization, avoidance of irritants and minimization of infection.

In terms of anti-inflammatory therapy, the mildest steroid possible should be used for as little time as possible. Flourinated steroids, in particular, need to be avoided to reduce steroid side-effects, such as atrophy and steroid-induced acne and perioral dermatitis. The calcineurin inhibitors (tacrolimus and pimecrolimus) have proved very effective for facial dermatitis and avoid the mentioned side-effects, while demonstrating a very good safety profile to date. Sensitive areas, such as the eyelids, can now be treated with much greater safety with these agents.

Answered by:
Dr. Scott Murray

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Plugging problems

2.

In PPI- and percutaneous endoscopic gastrostomy-fed patients, tube plugging is a common problem—any suggestions to resolve this?

Question submitted by:
Dr. Richard Wianecki
Ajax, Ontario

To try to prevent gastrostomy tube occlusion, use the largest diameter tube whenever possible. Tubes inserted using the percutaneous endoscopic technique are larger than those inserted either radiologically or surgically. Frequent tube irrigation can also reduce the rate of occlusion.

Two proton pump inhibitors (PPI), esomeprazole and lansoprazole, are best suited for administration via feeding tubes because they can be dissolved in water prior to administration.

Answered by:
Dr. Mark Borgaonkar

Blood work for ACEIs and ARBs

3.

What blood work and frequency of blood tests should we follow when combining an ARB with an ACE inhibitor?

Question submitted by:
Dr. Louise Linney
Ottawa, Ontario

The combination of angiotensin converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARB) is effective in managing difficult-to-control hypertension, in reducing proteinuria among diabetic patients and in treating patients with congestive heart failure (CHF). There is no consensus on how often patients should be tested when combining ACE inhibitors and ARBs.

In our group, if the baseline renal function (creatinine and blood urea nitrogen) is normal, we will monitor renal function, as well as serum potassium, approximately one to two weeks after the initiation of treatment. If the baseline renal function is abnormal, we will do the tests in three to four days. An increase in baseline creatinine > 30% or a potassium level > 5.6 mmol/L warrants a medication change.[1] After the initiation phase, renal function and electrolytes are checked every four to six months. If a change is made in dosage or if other medications are added, such as non-steroidal anti-inflammatory drugs, blood tests should be repeated. If the treatment is for CHF, electrolytes and renal function should be monitored more closely during followup due to the effect of aggressive diuresis or the addition of other CHF therapies.

Answered by:
Dr. Chi-Ming Chow

References
1. Palmer BF: Renal dysfunction complicating the treatment of hypertension. N Engl J Med 2002; 347(16):1256-61.

Outgrowing allergies

4.

When does a child outgrow egg allergies?

Question submitted by:
Dr. Michael Keating
Saint John, New Brunswick

The eight most common food allergens are:

- eggs,
- milk,
- wheat,
- soy,
- fish,
- shellfish,
- peanuts and
- tree nuts.

Some of these allergies tend to be life-long, such as allergies to peanuts, tree nuts and shellfish. Others, such as allergy to eggs, are usually outgrown.

Allergy to eggs usually manifests between six to 15 months of age, generally in children with atopic dermatitis. The majority of children outgrow their allergy to eggs by the age of three to seven years, although egg allergy may persist in some children.

Children may be allergic to the heat labile proteins in eggs and will react to raw or partially cooked eggs, or they may be allergic to the heat stable proteins in eggs and will react to all egg protein-containing products.

Answered by:
Dr. Peter Vadas

5. Fixing fibromyalgia

Does fibromyalgia ever go away?

Question submitted by:
Dr. L. Grbac
Toronto, Ontario

Fibromyalgia is a chronic musculoskeletal pain syndrome for which there is no cure. However, there are a minority of patients who recover from this condition. In our clinic, we have seen a few patients who report that their symptoms are no longer present. Unfortunately, none of these individuals are able to give a reason for their recovery.

It is important for patients to understand that there is no specific treatment for fibromyalgia. Patients need reassurance that they do not have a condition that will cause joint or muscle damage. This is done by excluding other conditions. They need to be educated about fibromyalgia, and they need advice on scheduling day-to-day activities and exercise. The role of health-care providers in this situation is to provide the support that the patient needs in order to develop a self-management program.

Answered by:
Dr. Liam Martin

6. What's recommended for spondylosis deformans?

Is there a recommended treatment for spondylosis deformans?

Question submitted by:
Dr. Don Spink
Peterborough, Ontario

Spondylosis deformans refers to bony proliferative osteophytes seen radiographically on the anterior and lateral aspects of the vertebral column. The pathologic process likely begins with weakening of the annulus fibrosis or outer shell of the intervertebral disc. Tissue breakdown at this site results in the loss of anchorage of the disc to the vertebral body and subsequent strain on the strong ligamentous attachments of the spine. Enlarging osteophytes develop where the anterior longitudinal ligament attaches to the vertebral body. Osteophytes may become large to form bridging connections between vertebral bodies.

These bony changes are more prevalent in older men, especially in those performing heavy physical work. By age 50, almost three quarters of the population will show spinal osteophytes. There is currently no preventative treatment available. Anterior osteophytes are mostly a radiographic curiosity without clinical consequence. Fortunately, posterior osteophytes, which could cause spinal cord compression, are rare. Large osteophytes in the lumbar region may cause a falsely elevated reading on bone density.

Although osteophytes do not cause clinical symptoms, the underlying ligamentous changes and stretching may be a factor in back pain. Management is, therefore, directed to good back care with maintenance of muscle tone and symptomatic pain relief, as needed.

Answered by:
Dr. Mary-Ann Fitzcharles

7. Dealing with GAD

What are the best treatments (both medical and therapeutic) for GAD?

Question submitted by:
Dr. Matthew Morgan
Halifax, Nova Scotia

Generalized anxiety disorder (GAD) is commonly under-diagnosed and under-treated, despite significant impairment and high co-morbidity. After exclusion of medical causes, treatment should be tailored on an individual basis to include behavioural psychotherapies (cognitive-behavioural therapy and anxiety/stress management techniques) and pharmacotherapy.

Serotonin reuptake inhibitors and venlafaxine, amongst the antidepressants, can be very effective, although relatively high doses may be required after slow initial titration (patients are somatically focused). Adjunctive drugs may include buspirone, benzodiazepines and beta-blockers, as well as gabapentin and pregabalin in research settings. The importance of avoiding all caffeinated products, alcohol, street drugs (including cannabis) and maintaining regular exercise must be reinforced with appropriate psychoeducation.

Answered by:
Dr. Pierre Chue

8. Myringotomy recommendation

What is the recommendation if a child has repetitive otitis media and we want to do a myringotomy?

Question submitted by:
Dr. Caroline Cabana
Mascouche, Quebec

When a child is referred with a history of acute otitis media (AOM), his developmental status should be assessed. The term "recurrent AOM" indicates four or more episodes of AOM in one year or three or more episodes in a six-month period.

Myringotomy and the insertion of pressure equalizing tubes should be considered for any child with a history of otitis media with effusion (OME) longer than four months associated with hearing loss or other signs or symptoms or concerning tympanic membrane changes, such as retraction pockets.

Other symptoms that are frequently present in a child with OME and could be indications for surgery include imbalance, unexplained sleep disturbance, otalgia and crankiness.

Answered by:
Dr. Ted Tewfik

9. Crohn's and renal calculi

Why are patients with Crohn's disease more likely to develop renal calculi?

Question submitted by:
Dr. Hayder Hatem
Fort McMurray, Alberta

Patients with extensive ileal disease or distal ileal resection are less able to absorb bile salts. As a result, there is less re-excretion of bile salts into the intestine and, hence, less fat absorption. Unabsorbed fat binds to intraluminal calcium in a process known as saponification, leaving less free calcium to bind to dietary oxalate. More unbound oxalate is, therefore, available for absorption, resulting in increased urinary oxalate excretion, thus increasing the likelihood of urinary oxalate precipitation and calculus formation.

Answered by:
Dr. Marty Fishman

10. Why can't I treat with this?

Why don't dermatologists want GPs to treat with clotrimazole and betamethasone?

Question submitted by:
Dr. Geo Poland
Pierrefonds, Quebec

This is not a "turf" issue, but a therapeutic one. The issue with clotrimazole and betamethasone is the strength of the topical steroid. No matter who uses topical steroids, the risk and appropriate precautions should be appreciated.

The ingredients of clotrimazole and betamethasone are betamethasone dipropionate, 0.05%, and clotrimazole, 1%. This is fine for an open area for a short time (*e.g.*, feet and torso), such as with inflammatory fungal infections, and this agent can be extremely effective. But the inclusion of a fluorinate steroid raises the risk of side-effects, such as skin atrophy and systemic steroid absorption. Therefore, great caution must be exercised and a good case must be demonstrated for use on the face, in folds or in occluded areas.

The use of this agent in the most common scenario (*e.g.*, diaper rashes) can be problematic as occlusion (diapers) can increase skin penetration by 10-fold or more. A more appropriate anti-inflammatory/anti-fungal/anti-yeast combination for such areas would usually be clotrimazole mixed with hydrocortisone for as short a time as possible, with appropriate clinical evaluation.

Answered by:
Dr. Scott Murray

11. In sinus rhythm on ECG—what to do?

A patient has been on amiodarone for 10 years since having an MI with cardiac arrest and resuscitation, followed by coronary artery bypass graft surgery. He is in sinus rhythm on ECG. Is it safe to take him off and what do I look for to decide this?

Question submitted by:
Dr. Laureen Ross, Calgary, Alberta

In this situation, each patient's treatment must be individualized. However, since the Multicenter Automatic Defibrillator Implanation Trial II (MADIT) was published,[1] we learned that patients with a previous myocardial infarction (MI) with a left ventricular ejection fraction (LVEF) < 30% or below benefited from having prophylactic implantable cardioverter defibrillator (ICD) therapy.

In this patient, LVEF estimation by non-invasive means, such as transthoracic echocardiography (ECG) or MUltiGated Acquisition nuclear (MUGA) study is helpful.

I would suggest referring this patient to a cardiologist to evaluate whether this particular patient needs to continue on amiodarone and to evaluate the need for implantable cardioverter defibrillator implantation.

Answered by:
Dr. Chi-Ming Chow

References
1. Moss A, Zareba W, Hall W, et al: For the Multicenter Automatic Defibrillator Implantation Trial II Investigators: Prophylactic implantation of a defibrillator in patients with myocardial infarction and reduced ejection fraction. N Engl J Med 2002; 346:877-83.

12. Diabetics on ACEIs?

Should all diabetics be on an ACE inhibitors?

Question submitted by:
Dr. A. Speiss Kelowna, British Columbia

Angiotensin-converting enzyme (ACE) inhibitors, in addition to their antihypertensive effects, have also been shown to reduce cardiovascular morbidity/mortality, allegedly due to beneficial effects on the endothelium. The Canadian Diabetes Association (CDA) guidelines recommends that vascular protection should be the top priority for patients with diabetes. Thus, we can infer that all patients with diabetes should be on an ACE inhibitor, even if they are normotensive and normoalbuminemic, at least per the CDA's recommendations.

If I were to prescribe an ACE inhibitor to a normotensive, normoalbuminemic diabetic specifically for vascular protection and to reduce cardiovascular mortality, I would only choose an agent that has been shown to provide this benefit in randomized, controlled trials, as all ACE inhibitors may not be equal.

Answered by:
Dr. Hasnain Khandwala

13. Injecting painful knees

I've seen very good results with corticosteroid injections in painful knees. Is there any evidence that more than three injections per year is harmful?

Question submitted by:
Dr. B. Toews
Coquitlam, British Columbia

The recommendation for a limit of three injections of corticosteroid per joint per year is a good starting point. This number has been quoted for years, but is based on clinical wisdom rather than on scientific evidence. The two major concerns regarding injecting joints are the risk of infection and bony necrosis. Infection is rare. A recent survey of 250 musculoskeletal physicians in England reported that only 12% had ever encountered joint infection related to joint injection. Even more rare is the occurrence of bony necrosis, which has only been described in a few case reports.

Corticosteroid injection for osteoarthritis of the knee has shown to be effective for pain relief in the short term, but without any clinical predictors for a good response. Common sense should dictate the clinically acceptable frequency for injecting an individual joint. Pain relief should ideally last for up to three to four months. Repeated joint injections may be useful for the patient who shows a moderate response, but is not a candidate for a surgical procedure.

Even in established osteoarthritis of the knee, examination may indicate that an important site of pain is located in the anserine bursa. For this reason, occasionally injecting the anserine bursa rather than the knee joint may be useful. A corticosteroid shot in the knee is a small price to pay for the maintenance of physical activity.

Answered by:
Dr. Mary-Ann Fitzcharles

Corticosteroid injection for osteoarthritis of the knee has shown to be effective for pain relief in the short term.

ALTACE 10mg
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Angiotensin converting enzyme inhibitor
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14. Black eye worries

Do black circles under the eyes of children mean anything? Some children have no signs and symptoms of allergies/atopy—parents worry about this sign.

Question submitted by:
Dr. Jean Meskey
Vernon, British Columbia

Black circles under the eyes are common in two circumstances, the first being in allergic children. The second circumstance is a normal variant (*i.e.*, some children who normally have a somewhat dark area under their eyes).

The first case suggests the need for control of the child's allergies. In the second case, parents merely need reassurance that their children are normal and that no investigation or therapy is merited.

Answered by:
Dr. Michael Rieder

15. Methylphenidate for Mom and Dad

I have recently been getting a number of adults requesting prescriptions for ADHD. Often, they have a child on methylphenidate and feel they have the same problem as their child. A psychologist has told them they need medication. What do the experts say?

Question submitted by:
Dr. Barbara Lancing
Calgary, Alberta

Attention-deficit/hyperactivity disorder (ADHD) affects 30% to 50% of adults who had ADHD in childhood. In addition, mothers and fathers of children with ADHD are 24 times and five times more likely to have ADHD, respectively. Accurate diagnosis of ADHD in adults is complicated by the overlap with other psychiatric illnesses, such as bipolar disorder, generalized anxiety disorder, personality disorders and substance abuse. Furthermore, only 30% to 50% of adults who believe they have ADHD actually meet formal diagnostic criteria. In adults, impulsivity and deficits in sustained attention and concentration are likely to remain, whilst hyperactivity tends to be replaced by restlessness, difficulty relaxing and chronic feelings of being "on edge."

Answered by:
Dr. Pierre Chue

16. Checking for insulin resistance

How do you check for insulin resistance in a patient?

Question submitted by:
Dr. S. Vaidyanathan
Toronto, Ontario

The gold standard for measuring insulin resistance is the euglycemic clamp, which is not practical in the clinical setting. Body mass index and waist circumference correlate positively with insulin resistance. The presence of acanthosis nigricans, hypertension, high triglycerides, low high-density lipoprotein and microalbuminuria also suggest insulin resistance. Measuring fasting insulin levels, *etc.*, though often done, is not always helpful, as a patient with significant insulin resistance may have "normal" insulin levels if they also have relative insulin deficiency.

Answered by:
Dr. Hasnain Khandwala

17. Caution: Meds to avoid in Crohn's

What medications are best to avoid when people have Crohn's disease?

Question submitted by:
Dr. Chantal Joron
St. Eustache, Quebec

No medications are absolutely contraindicated in Crohn's patients. Non-steroidal anti-inflammatory agents (NSAID), oral contraception (OCP) and cigarette smoking have all been associated with an increased risk of a Crohn's flare. Therefore, patients should be strongly encouraged to refrain from smoking. NSAIDs and OCPs may be used, but patients should be informed of the potential risks and should use NSAIDs sparingly, if possible.

Infectious colitis, including *Clostridium difficile* infection, is linked with a higher rate of disease flare. For this reason, antibiotics should be used judiciously.

Answered by:
Dr. Mark Borgaonkar

18. Evaluating LBBB

A healthy 55-year-old woman had LBBB identified during cosmetic surgery. She has no significant risk factors for heart disease. Are other investigations needed?

Question submitted by:
Dr. George Inman
Victoria, British Columbia

Left bundle branch block (LBBB) is an uncommon electrocardiographic finding in healthy subjects and is usually associated with underlying heart disease. The most common causes include coronary artery disease, left ventricular dysfunction and hypertension-induced left ventricular hypertrophy. LBBB is associated with worsening heart failure and the development of heart disease.

For this 55-year-old woman, a careful history and physical examination should be undertaken to look for structural heart disease or hypertension. Most would probably recommend an assessment of ventricular function with an echocardiogram and long-term followup to watch for manifestations of heart disease.

Answered by:
Dr. Todd Anderson

And the Winner is...

Dr. Arthur William Karr!

CME congratulates Dr. Karr! Here are a few facts about our winner:

- **Medical affiliations:** Medical Consultant, Ontario Workplace Safety and Insurance Board
- **Medical interests:** Assessment of musculoskeletal disability, with a special interest in repetitive strain injuries in assembly line workers
- **Leisure interests:** Music (listening and playing piano/organ); licensed Unity Teacher, spiritual leader (one of three) of Unity of Guelph; licensed by the Province of Ontario to perform weddings
- **Will use the Palm Pilot to:** Access medical literature and keep himself organized!