CONSULTANT'S CORNER

Practical answers to your everyday questions

This month—12 Answers:

1. Adult ADHD—does it exist?

Is adult attention deficit hyperactivity disorder (ADHD) a reality? If so, what is the recommended treatment?

Question submitted by:
Dennis Francis, MD
Victoria, British Columbia

Modern imaging and electroencephalogram (EEG) studies have established probable cerebral sites for adult ADHD. Studies have tracked children into adulthood and noted continuing signs.

Individuals with correctly diagnosed adult ADHD benefit immediately and enormously from stimulants, usually longer-acting versions of d-amphetamine and methlyphenidate. Marriages, parenting and workplace efficiency improve. Students taking examinations benefit through better attention and improved short-term memory.

These stimulants may also be helpful for any concurrent smoking habits and depression.

Do not discontinue successful medication without good reason.

Resource

1. Weiss M, Hechtman L, Weiss G: ADHD in Adulthood: A Guide to Current Theory, Diagnosis and Treatment. Hopkins Fulfilment Service, 2001.

Answered by:
Peter C. Matthews, MD, FRCPC
Clinical professor of psychiatry
University of Saskatchewan
Department of psychiatry
Royal University Hospital
Saskatoon, Saskatchewan

2. Metformin for PCOS?

Use of metformin in polycystic ovarian syndrome (PCOS) is now well established. Is there an indication to use metformin in PCOS, even if fertility or periods are not an issue?

Question submitted by:
Gary Barrs, MD
Montreal, Quebec

I disagree that the use of metformin in PCOS is well established. Its role is still being studied.

In theory, it will lower the insulin levels, thus, improving the clinical features. In practise, it is often poorly tolerated and the results are modest at best.

I do not believe metformin is to be used as a routine, nor is it the first-line drug for any of the various clinical problems a woman with PCOS may have; other treatments are superior. Furthermore, use of metformin may illicit patients expecations (*e.g.* marked weight loss) that may not be met. Thus, counselling is critical.

Resources

1. Azziz R: We should avoid the indiscrimination use of insulin sensitizers in women withpolycystic ovary syndrome. Fertil Steril 2003; 80(2):264-5.
2. Ganie MA, Khurana ML, Eunice M, et al: Comparison of efficacy of spironolactone with metformin in the management of polycystic ovary syndrome: an open-labeled study. J Clin Endocrinol Metab 2004; 89(6):2756-62.

Answered by:
Bernard Corenblum, MD, FRCPC
Professor of medicine
University of Calgary
Active staff
Foothills Medical Centre
Calgary, Alberta

3. What's best for managing ACL tears?

For anterior cruciate ligament (ACL) tears in people over age 50, how does conservative treatment compare to surgery?

Question submitted by:
Cynthia Watson, MD
Kamloops, British Columbia

Nowadays, people over 50 can be very active. The selection of a treatment option should be made with consideration for preoperative instability and the desired level of activity. This is especially true, as the outcome of surgery does not seem age-dependent.[1]

Rehabilitation plays a crucial role in whether or not surgical reconstruction is performed. If a patient has a very unstable knee or wants to remain involved in an activity characterized by a combination of important decelerations, shifts of direction, jumps and/or irregular surfaces (such as soccer, downhill skiing, moguls, cross-country running, *etc.*), surgery might be considered.

Reference
1. Barber FA, Elrod BF, McGuire DA: Is an anterior cruciate ligament reconstruction outcome age dependent? Arthroscopy 1996; 12(6):720-5

Answered by:
Pierre Frémont, MD, PhD, CCMF, Dip Med Sport (ACMS)
Department of family medicine
Centre Hospitalier de l'Université de Laval
Quebec, Quebec

4. Dealing with tinea versicolor

What is the easiest way to treat tinea versicolor?

Question submitted by:
James R. Gray, MD
Vancouver, British Columbia

Tinea versicolor is a yeast infection that produces a scaley, brownish-red eruption on the torso. With sun exposure, it can give a rather bizarre white "confetti-like" appearance.

More common in young people, it is usually asymptomatic.

Treating it is rather easy; tinea versicolor responds to topical anti-yeast agents, such as:

- soaps (zinc pyrithione, 2%),
- shampoos (zinc pyrithione, selenium,ketoconazole, ciclopirox),
- a wide variety of anti-yeast creams, lotions, sprays and
- oral medications, such as ketoconazole.

The trick is the eruption tends to re-establish itself in sucseptable indiviuals, so maintenance treatment is needed once in a while.

In addition, for the scalp, I also like to use anti-yeast measures, as a shampoo as the causitive yeast (*Pityrosporum ovale*) tends to colonize the scalp and add to recurrences. This tendency for recurrence is why I prefer to show the patient how to self-treat with a simple, inexpensive agent, such as a zinc pyrithione, 2% bar, selenium sulfide, shampoo (mixed equal parts with water) with a prophylactic treatment every few weeks to prevent the rash from re-establishing itself.

Answered by:
Scott Murray, MD, FRCP(C)
Associate professor
Dalhousie University
Halifax, Nova Scotia

5. Are allergy and mood connected?

Are there specific mood changes related to allergic rhinitis?

Question submitted by:
Jayprakash Patidar, MD, DCH, FCP (Pediatrics)
Brandon, Manitoba

The issues of mood changes and impairment of quality of life in allergic rhinitis are very important from the patient's standpoint, but generally not well appreciated by the treating physician. There have been many studies documenting mood disturbances in allergic rhinitis.

Allergic rhinitis may cause changes in the affected individual's mood affect and other aspects of personality.[1] In children, allergic rhinitis may result in decreased ability to concentrate, bouts of irritability and temper tantrums.[2] Many adult patients complain of fatigue, moodiness and dysphoria during their allergy seasons.[3]

Patients with seasonal allergic rhinitis reported higher levels of general fatigue and mental fatigue, greater sadness and reduced pleasurable engagement with symptomatic allergies arising from sleep fragmentation.[3,4] Using disease-specific validated instruments, such as the Nocturnal Rhinoconjunctivitis Quality of Life Questionnaire and the Pittsburgh Sleep Quality Index, treatment with intranasal steroids resulted in statistically significant improvements in rhinitis-related quality of life and sleep quality scores.[5]

However, effective treatment is not restricted only to intranasal steroids, but also includes appropriate avoidance of airborne allergens to minimize ongoing exposures, use of non-sedating antihistamines and, where appropriate, either preseasonal or conventional aqueous allergen immunotherapy.

References
1. Storms WW: Treatment of allergic rhinitis: Effects of allergic rhinitis and antihistamines on performance. Allergy Asthma Proc 1997; 18(2):59-61.
2. Klein GL, Ziering RW, Girsh LS, et al. The allergic irritability syndrome: Four case reports and a position statement from the Neuroallergy Committee of the American College of Allergy. Ann Allergy 1985; 55(1):22-4.
3. Marshall PS, O'Hara C, Steinberg P, et al: Effects of seasonal allergic rhinitis on fatigue levels and mood. Psychosom Med 2002; 64(4):684-91.
4. Craig TJ, Teets S, Lehman EB, et al: Nasal congestion secondary to allergic rhinitis as a cause of sleep disturbance and daytime fatigue and the response to topical nasal corticosteroids. J Allergy Clin Immunol 1998; 101(5):633-7.
5. Mintz M, Garcia J, Diener P, et al: Triamcinalone acetonide aqueous nasal spray improves nocturnal rhinitis-related quality of life in patients treated in a primary care setting. Ann Allergy Asthma Immunol 2004; 92(2):255-61.

Answered by:
Peter Vadas, MD, PhD, FRCPC, FACP
Director, Division of allergy and clinical immunology
St. Michael's Hospital
Toronto, Ontario

6. Is it lymphoma?

Abdominal ultrasound scanning on a five-year-old boy found large lymph nodes. Do I need to follow-up? Could this be lymphoma?

Question submitted by:
Kathryn Lockington, MD, CCFP
Kingston, Ontario

Enlarged abdominal lymph nodes in children can be attributed to various conditions, including reactive or neoplastic process. However, the most common reasons for enlarged lymph nodes (lymphadenopathy) are related to infections, such as viral, bacterial or other organisms, including fungal and mycobacterial organisms.

Occasionally, lymphadenopathy occurs in association with inflammatory bowel diseases. Autoimmune diseases and benign reactive enlargement without known etiology can also cause lymphadenopathy.

Fortunately, each disease or reaction has a unique way of presenting and the physician will be able to make a proper diagnosis from the patient's signs and symptoms.

If the diagnosis of lymphoma is suspected, or the diagnosis is unclear to the physician, further investigations will be required. These investigations may, or may not, include a repeat of the ultrasound, depending on the nature of the suspected illness.

Answered by:
Kamillia Rizkalla, MD, FRCPC
Associate professor
University of Western Ontario
Hematopathologist
London Health Sciences Centre
London, Ontario

7. Is B_{12} brain food?

Does vitamin B_{12} always improve cognitive status in the deficient elderly patient?

Question submitted by:
Jean Ouellette, MD, FRCPC
Hawkesbury, Ontario

Unfortunately, replacing vitamin B_{12} does not always improve cognition. Many patients have other etiologies for their cognitive impairment (such as Alzheimer's disease) and supplementing with B_{12} might not result in obvious clinical cognitive improvement.

If B_{12} deficiency is contributing to the dementia, however, some cognitive improvement might be noted. Thus, the use of vitamin B_{12} is always appropriate.

A further goal of treatment is to arrest or prevent the development of complications such as:

- megaloblastic anemia,
- orthostatic hypotension or
- posterior column disease.

Many of these manifestations of B_{12} deficiency will have an adverse effect on quality of life for any patient, including those with dementia.

Answered by:
Michelle Gibson, MD, CCFP,
Lecturer,
Division of geriatric medicine,
Queen's University,
Kingston, Ontario

8. Following ADPKD

How do you follow a patient with adult polycystic renal disease?

My patient is in her mid-40s and the liver is also affected by the disease. Her mother died of the disease after she had chronic renal failure. Do I need to follow her with regular scans and, if yes, how often?

Question submitted by:
Heyder Hatem, MD, MB, CHB, LMCC, FRCS, DFFP, DPD
Fort McMurray, Alberta

Routine ultrasounds/computed tomography scans are not necessary after the initial diagnosis has been made. They are used to investigate complications of autosomal dominant polycystic kidney disease (ADPKD) (*i.e.,* hematuria).

Long-term management would include the following:

- renal function,
- hypertension (≤ 130/80 mmHg),
- anemia management (>110 g/l).

Manage painful complications such as:

- infection or hemorrhage of cysts and
- renal stones (up to 20% of polycystic kidney disease patients).

Screen for extrarenal manifestations of the disease (if indicated), including:

- hepatic involvement (using ultrasound),
- cerebral aneurysms,
- heart valves,
- colonic diverticulae and
- adominal hernias.

Answered by:
James Barton, MD, FRCPC (Nephrology)
Clinical assistant professor of medicine
University of Saskatchewan
Staff nephrologist
St. Paul's Hospital
Saskatoon, Saskatchewan

9. Asthma—too young to diagnose?

Can asthma be accurately diagnosed in a patient under two years of age?

Question submitted by:
Roshan Dheda, MD, MB, BCh, LMCC, CCFP
Bradford, Ontario

The diagnosis of asthma in children is challenging, as spirometry in the young child is difficult. This means the diagnosis will have to be a clinical one. A good history and physical examination are key factors in the diagnosis.

Often, diagnosis may not be made on the first visit, but only after recurrent symptoms are found to be present. The Canadian Asthma Consensus Report states that establishing the diagnosis of asthma in the young patient depends on the following:

- episodes of wheezing,
- wheezing after one year of age,
- more than three episodes of wheezing in a year,
- a family history of asthma or atopy,
- a personal history of atopy,
- clinical improvement after anti-inflammatory treatment,
- chronic cough, especially nocturnal or exercise-related and
- wheezing when viral etiology is unlikely.

The likelihood of a diagnosis increases with the number of these factors present.

Answered by:
Moyez Ladhani, MD, FRCPC
Associate clinical professor
McMaster University
Hamilton, Ontario

10. How should you treat dyspepsia?

Can you recommend treatment options for functional dyspepsia?

Question submitted by:
Mark Atin, MD, FRCPC
Toronto, Ontario

Moses Maimonedes is quoted as saying "teach thy tongue to say 'I do not know.'" This question would be a perfect example of when to practise that sage advice.

There is no single "best treatment" for nonucler dyspepsia (NUD), as there is no clearly defined etiology. However, there are a number of considerations:

1. Be sure you are dealing with NUD by ruling out organic disease. There is a huge difference between uninvestigated dyspepsia and NUD. As far as I am concerned, this is the most important "rule."
2. You can eradicate *Helicobacter pylori*, if present. Your chances of ridding the patient of dyspeptic symptoms are, however, not that good, with a number needed to treat of approximately 14 (at best).
3. Most pharmacologic approaches to the management of NUD have only limited therapeutic gain over placebo. Acid suppression is a reasonable first step in most cases, but high doses may be required. Prokinetic agents can be considered as an alternative, although the physiologic rationale for the use of these agents is somewhat convoluted.
4. Truly refractory patients may benefit from treatment with antidepressants and psychologic treatment approaches, but my advice would be to refer these patients to an expert before you go down that road.

Suggested reading
1. Tac J, Bisschops R, Sarnelli G: Pathophysiology and treatment of functional dyspepsia. Gastroenterology 2004;127(4):1239-55.

Answered by:
Jacob Louw, MBChB, FCP(SA), FRCPC, Med PhD
Professor of medicine
Division of gastroenterology and Department of medicine
Queen's University
Kingston, Ontario

11. Mitigating monster migraines

What is optimal treatment for migraine?

Question submitted by:
Patricia Baass MD
Toronto, Ontario

In this past decade, with the advent of potent symptomatic treatments, the emphasis has been placed on fast and complete elimination of migraine symptoms.

The current recommendation to patients with high needs is centred around the use of early, specific therapy with one of the triptans or dihydroergotamine.

The effect of early treatment on pain control at two hours and at 24 hours can be further amplified with the early combined use of a triptan with non-steroidal anti-inflammatory drug (NSAIDs) and, in some cases, with metoclopramide. With such a strategy, most patients will be allowed to rapidly resume their usual activities.

Such an approach does not, however, take care of the initial cerebral events that lead to development of a migraine attack. Here, the strategy should be based on the identification of potential trigger factors and their avoidance.

Prophylactic treatments that would normalize the altered cerebral reactivity present in migraine are yet to come, although the commonly used prophylactic agents (tricyclic antidepressants, beta blockers and anti-epileptics) do tend to attenuate the cerebral hyperactivity associated with migraine.

There are several indications for prophylaxis in migraine, but in general, prophylaxis should be considered if the frequency of migraine attacks is close to one attack per week.

Answered by:
Michel Aubé, MD
Montreal Neurological Institute
McGill University
Montreal, Quebec

12. Can BTX-A do harm?

What are some of the possible complications of cosmetic botulinum toxin A (BTX-A) injections to the face?

Question submitted by:
Peter Palmer, MD
St. Albert, Alberta

In the manufacturer's phase three studies of BTX-A which led to approval in both Canada and the U.S., the commonest side-effect was headache. This occurred at approximately equal rates in both the placebo and active drug groups and, therefore, was probably due to the injection rather than the drug.

The other problem which occurred in significant numbers was eyelid ptosis. However, with good technique, eyelid ptosis should be unusual. An incidence > 0.1% would indicate that technique needs to be improved. Eyelid ptosis should be relatively short-lived and will often respond to appropriate treatment.

Perhaps a more severe complication in the brow area is drooping of the eyebrows, indicating either treatment of an inappropriate candidate or treatment of the frontalis muscle.

In addition, BTX-A can increase and decrease function in various muscles that may be asymmetric. The physician injecting BTX-A needs to know and understand anatomy well and be skilled in the use of BTX in order to avoid or manage such complications.

Finally, the worst complication of the use of BTX on the face is to reduce expressivity and it should always be the aim of the treating physician to retain an individual's expressivity and individuality.

cme

Answered by:

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