



This month—10 Answers:

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1.

Treating Graves' disease

How long can a patient safely take methimazole for Graves' disease if they opt not to be treated with radioactive iodine?

Question submitted by:
S. Waltzer, MD
Ajax, Ontario

Unless thyrotoxicosis is self-limited (such as thyroiditis) or iatrogenic, management choices directed toward the thyroid gland include thyroidectomy, radioiodine or antithyroid drugs (propylthiouracil and methimazole).

Each therapeutic choice has several advantages and disadvantages, with patient preference being a major factor.

Long-term therapy with antithyroid drugs is not usually used, as the other more definitive choices of therapy are offered if relapse occurs.

Most of the adverse reactions with antithyroid drugs occur in the first few months, with little added risk in long-term use. If the hyperthyroidism does not enter remission after one or more courses of antithyroid drugs and alternate therapies are not acceptable for the patient, there is no reason why long-term use of antithyroid drugs cannot be used to control the hyperthyroidism.

Answered by:
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2.

BPD and BD—What's the difference?**What are the clinical dilemmas between borderline personality disorder and bipolar disease Type II? Can we tell a patient that they have both?**

Question submitted by:
Pierre Rondeau, MD
Montreal, Quebec

Several studies have reported a high degree of comorbidity between bipolar disorder (BD) and borderline personality disorder (BPD). Some view BPD as a variant of BD because of shared phenomenology (affective instability and impulsivity) and documented therapeutic efficacy of mood stabilizers in both conditions.

It is often difficult to establish if a patient suffers from BD, BPD or both. Clinicians should be aware that these conditions are not mutually exclusive and they often co-exist. In addition to the history of

depression and hypomania (BD Type II), the developmental history, feeling of emptiness, impulsivity and persistent unstable interpersonal relationships during euthymia may suggest the co-existence of BD and BPD.

The second clinical challenge is the management of this comorbidity. BD has been conceptualized as a genetically determined, biochemical illness that could be stabilized by mood stabilizers, whereas BPD is considered a personality disorder caused by developmental difficulties best treated by psychosocial treatments. Hence, the expectations of the patient are to take a passive stance towards BD and take personal responsibility towards BPD. This dual approach may confuse the patient.

The best strategy is to address the common underlying dispositions and symptoms and implement common treatment approaches targeting both conditions. The treatment goals include mood stabilization and effective psychosocial functioning.

Mood stabilizers, such as valproic acid or lamotrigine, are effective in both conditions. Psychosocial treatments focusing on interpersonal problems and crisis and stress management will be beneficial for both BPD and BD.

Having a split view of a patient's illness and treatment approaches may cause problems to the treatment team. Team meetings will help to resolve split views and develop a co-ordinated approach.

Answered by:
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3.

“Why can’t my kid sleep?”

What are the common causes of insomnia in children and does drug therapy have any role in treatment?

Question submitted by:
J.V. Patidar, MD
Edmonton, Alberta

Table 1

Causes of insomnia in children

- Bedtime resistance and poor sleep hygiene.
- Insomnia associated with stress reactions, psychiatric or physical illness.
- Specific sleep disorders, such as restless legs syndrome and respiratory sleep disorders.

Common causes of insomnia in children are age-related. The prevalent etiologies for infants and younger children are:

- persistent nighttime feedings,
- separation and temperamental issues,
- bedtime resistance and
- co-sleeping.

In these situations, behavioural interventions (*e.g.*, tapered feeding schedule, establishing a consistent sleep schedule and enforcing it with firm limit setting) are the treatments of choice.

As the child ages, numerous causes of insomnia present (Table 1) and these may require specialist assessment and treatment.

Severe insomnia, causing significant distress or dysfunction in the child or parents may require brief courses of sleep-promoting agents in conjunction with behavioural strategies.

Drug therapy in this age group has been inadequately studied, although benzodiazepines, chloral hydrate, antihistamines and melatonin are frequently used. In the absence of good studies, the safest option is the occasional use of low-dose, short-acting benzodiazepines (*i.e.*, oxazepam) or, possibly, a benzodiazepine agonist (*i.e.*, zaleplon).

Sedating antihistamines should not be used as they have a long half-life and may cause cognitive and psychomotor impairments the next day.

Answered by:
Jonathan Fleming, MD, FRCPC
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4.

Asking about antihypertensive therapy

Does isolated diastolic pressure elevation require antihypertensive therapy?

Question submitted by:
A. Kayumi, MD
Mississauga, Ontario

A common situation in clinical practice is a young patient with elevated diastolic pressure and a normal systolic reading, such as 135/95 mmHg or isolated diastolic hypertension.

The latest Canadian Hypertension Education Program (CHEP) 2005 recommends that any diastolic pressure ≥ 90 mmHg be considered as hypertensive.

Traditionally, diastolic pressure has been regarded as the most important of the three measures (the others being systolic and pulse pressure), but recent attention has been focused on the benefits of treating isolated systolic hypertension and pulse pressure taking over as the more powerful risk marker for middle-aged and elderly subjects.

Multiple epidemiologic studies, including a worksite hypertension control program, a healthy Finnish men study, Japanese Ohasama study and the Honolulu Heart Program, all suggest that an isolated diastolic pressure elevation is not associated with an adverse prognosis, as long as the systolic pressure is < 140 mmHg.

It would appear reasonable not to prescribe antihypertensive treatment for patients who present with an elevated diastolic pressure and a systolic pressure < 140 mmHg at the present time.

The current CHEP recommends considering treatment only if:

1. Average diastolic blood pressure is ≥ 90 mmHg with hypertensive target-organ damage (or cardiovascular damage) or there is presence of independent cardiovascular risk factors.
2. Average diastolic blood pressure is ≥ 80 mmHg in diabetic patients.

When treating elderly patients with isolated systolic hypertension, the diastolic pressure (which is normal to begin with) is also most often reduced. It turns out that if the diastolic pressure in these elderly patients is reduced too much (below 65 mmHg to 70 mmHg) the risk of stroke has been shown to increase.

Answered by:
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5.

Who will benefit from montelukast?

Do people who are receiving allergy desensitization injections benefit from montelukast?

Question submitted by:
Larry Bobyn, MD
Kelowna, British Columbia

There are two situations in which patients on allergy desensitization injections might benefit from montelukast.

First, if they have allergic rhinitis, there is evidence that montelukast, taken with an antihistamine, will help control the nasal symptoms.

Second, in patients with allergic asthma, montelukast may help to control the asthma symptoms that have not responded to the immunotherapy and concomitant symptomatic treatments, such as inhaled corticosteroids and/or long-acting bronchodilator medications, such as salmeterol, formoterol or the combinations salmeterol and formoterol.

In mild seasonal asthma, there may occasionally be an indication to use montelukast with immunotherapy alone, if there are occasional breakthrough symptoms. Such patients should always be given a rescue medication, such as salbutamol or terbutaline. If the use of rescue medication is more than two to three times per week, then additional therapy (*i.e.*, inhaled corticosteroids) should be given.

Answered by:
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6.

Too old for a PSA test?

When should you consider a patient "too old" for a PSA test to be of any useful significance?

Question submitted by:
Daniel Berendt, MD
Edmonton, Alberta

There is no clear-cut answer. Original guidelines recommend not measuring prostate-specific antigen (PSA) in men over 70 years. However, some men are in excellent health at this age and, especially if there is a family history of longevity, a PSA measurement is reasonable.

Life expectancy of more than 10 years is also a helpful guide. One must remember that the older the man, the greater the risk of prostate cancer, but the lower the risk of dying from it.

Sometimes the treatment is worse than the disease. Patient expectation can drive tests, but should not always be satisfied.

Answered by:
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7.

SSRIs and sex

What treatment options are there for treating sexual dysfunction associated with SSRI use? Which SSRIs have the best efficacy with lowered risk of sexual dysfunction?

Question submitted by:
A. Kayumi, MD
Mississauga, Ontario

Treatment options for sexual problems with selective serotonin reuptake inhibitors (SSRIs) include:

- changing SSRI for another (*e.g.*, fluoxetine, mirtazepine or citalopram); more distress with fluvoxamine, paroxetine, venlafaxine and sertraline;
- waiting to see if problems diminish, since depression can also cause sexual problems;
- using counselling by a specialist;
- using a different antidepressant, such as bupropion or a tricyclic antidepressant or
- using electroconvulsive therapy.

My opinion about the least sexually distressing SSRI is citalopram, fluoxetine or trazadone (the latter can rarely cause priapism, which is a different kind of sexual problem).

Answered by:
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8.

Does early vitamin use lead to food allergies?**Can you comment on a recent report linking early vitamin use and food allergies in children?**

Question submitted by:
Leonard Grbac, MD
Toronto, Ontario

A recent study of 8,000 infants for development of allergies and asthma found a positive association between vitamin supplementation in the first six months of life and the risk of asthma in African-American children.

All infants given vitamin supplementation were about 70% more likely to develop food allergies than those who had no extra vitamins in their diet. Similarly, the overall risk of developing food allergies (but not asthma) was increased in all children receiving supplementary vitamins at age three, irrespective of whether they were breast-fed or formula-fed.

This study does not establish any cause-effect relationship between vitamin use and the risk of developing either food allergies or asthma.

The overall prevalence of all atopic diseases has been on the rise for at least two decades and the use of vitamin and other naturopathic supplements has also been increasing. However, these data do not establish any linkage between the two trends.

There are other studies that show the opposite trend. For example, a recent publication showed that antioxidant vitamin E intake during pregnancy was negatively associated with development of wheezing and childhood eczema.¹

At this stage, these studies should not influence recommendations for vitamin use during pregnancy, lactation or early childhood.

Recommendations for vitamin supplementation should be based on the adequacy of the child's diet and the presence of any factors that might lead to malabsorption of necessary nutrients.

In children with strong family or personal histories of atopic disease, appropriate environmental control measures should be implemented in the child's environment and specific treatment for allergies or asthma should be instituted, if necessary.

References

1. Martindale S, McNeill G, Devereux G, et al: Antioxidant intake in pregnancy in relation to wheeze and eczema in the first two years of life. *Am J Respir Crit Care Med* 2005; 171(2):121-8.

Answered by:
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9.

Cholesterol treatment choices

What would be the next line of therapy for someone who can not tolerate fibrates or statins?

Question submitted by:
E.P. Musoke, MD
Melfort, Saskatchewan

The next line of therapy would depend on the primary lipid abnormality being treated.

If one wishes to mainly lower the low-density lipoprotein cholesterol level:

- Ezetimibe could be tried as monotherapy, though it is less potent than statins.
- The older bile-acid sequestrant resins, cholestyramine and colestipol, could be used as well.

If one wishes to lower triglycerides or raise high-density lipoprotein cholesterol:

- A different form of sustained-release niacin, which has been trialed successfully in the U.S., will soon become available in Canada.
- Fish oils (in capsule form) can also be tried.

Answered by:
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Adult ADHD

10.

What is the current first-line approach to managing ADHD in adults?

Question submitted by:
Lori Regenstreif, MD
Hamilton, Ontario

Attention-deficit hyperactivity disorder (ADHD) affects 30% to 50% of adults with previous childhood ADHD.

Accurate diagnosis of ADHD in adults is challenging and is further complicated by overlap with other psychiatric conditions (bipolar, anxiety, substance abuse, borderline and antisocial personality disorders).

As with children, stimulants are the most commonly used class of medications, but should be used cautiously in patients with a history of substance abuse. Thus, confirmation of diagnosis is important since adults may require larger dosages than children.

Antidepressants may also be effective, particularly tricyclic antidepressants (secondary amines) and bupropion, while selective serotonin reuptake inhibitors appear less effective.

Psychotherapy, including cognitive-behavioural skills training, may be a useful adjunct to medication.

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Answered by:
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