This month—10 Answers:

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1. Referring floaters

When should I refer eye floaters?

Question submitted by:
Hans Gue, MD
Toronto, Ontario

Urgent referral to an ophthalmologist should be made under these circumstances:

- Loss of corrected vision (you must test each eye separately)
- Brief light flashes (photopsia) accompanying the floaters (not the scintillation of migaine)
- Previous eye surgery
- Shadow or curtain (retinal detachment)
- Red or pink/red floaters (vitreous hemorrhage)

Non-urgent referral is acceptable when floaters last longer than two months or do not have the above characteristics (but pathology is still possible).

The prompt vitreoretinal examination of each patient aged over 45 with vitreous floaters should be undertaken without delay. The goal is to diagnose retinal breaks and retinal detachments before they can threaten vision.

Acute vitreous floaters are associated with a significant risk of intraocular pathology. Appropriate referral can be made on the basis of an adequate history and a simple evaluation of each eye's corrected visual acuity. Fundus examination by the family physician is not essential.

Answered by:
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2. Sports and spondylolysis

A 24-year-old hockey player is becoming increasingly limited by lumbar back pain. An X-ray shows spondylolysis L5. What are the surgical indications for intervention in spondylolysis?

Question submitted by:
Jeffrey W. Lynskey, MD
Powell, British Columbia

Surgical intervention is typically required when conservative treatment has failed. However, this is rarely the case.

Several studies have adressed the treatment of athletes with spondylolysis, but there is no evidence to prove which method is most effective.[1,2,3] Treatment should be individualized and focused on eliminating pain, preparing for return to normal activities and preventing recurrence (Table 1).

Preventing recurrence may be difficult. It is important to keep a maintenance training program, to avoid repetitive hyperextension activities and to report any recurrence immediately.[4]

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Answered by:
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Table 1

Proposed treatments for spondylolysis

Stage	Treatment
Stage 1	• Removal from athletic activities for 4 to 6 weeks • Ice, heat, non-steroidal anti-inflammatory drugs, muscle relaxants, narcotic analgesics (use only to allow activities of daily living) • Physical therapy: Hamstring flexibility, lumbar dorsal stretching and abdominal strengthening
Stage 2	• Thoracolumbar dorsal orthosis 23 hours a day for 3 to 6 months (it is debatable if a brace should be worn earlier in stage 1) • Wearing a brace on a 6-month basis • If patient is asymptomatic, the brace can be slighty trimmed for the patient to participate in athletic activities
Stage 3	• Pulsed electromagnetic therapy 8 hours a day
Stage 4	• Discuss surgical intervention

3. Discussing antidepressant therapy

What is the optimal duration of antidepressant therapy for a first episode of depression?

Question submitted by:
G. Inman, MD
Victoria, British Columbia

Depression ranges from relatively brief episodes to the initial presentation of a severe, chronic illness.

Although estimates vary, 15% to 25% of patients with the Diagnostic and Statistical Manual of Mental Disorders' (fourth edition) definition of major depressive disorder may go on to experience bipolar disorder, recurrent major depression or other serious disorders.

Any treatment of depression should include a detailed life and family history, as well as a full medical workup. With this in mind, Canadian practice guidelines suggest continuing antidepressant therapy for six months following complete resolution of a first uncomplicated episode of depression. If the antidepressant is discontinued, it should be tapered over several weeks.

Answered by:
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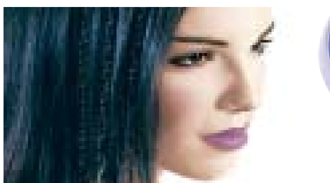

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4. Pondering prostate cancer treatment

Should an 80-year-old man with prostate cancer (no metastases) be treated aggressively?

Question submitted by:
Dinesh P. Sinha, MD
Sheet Harbour, Nova Scotia

The treatment decision should be based on the patient's wishes, general health, symptoms, grade of cancer and clinical stage.

In general, the older the patient, the more conservative the treatment. In most cases, a "watchful waiting" approach would be the preferred option. This does not mean leaving the patient alone; rather, serial prostate-specific antigen (PSA) measurements, a digital rectal examination and a symptom assessment would be appropriate.

PSA doubling time is becoming a guide for intervention. Doubling time less than one year is indication for active treatment.

Intervention may be external beam radiation, brachytherapy, cryoablation or hormonal therapy, depending on the factors mentioned above.

Answered by:
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5. Can ultrasounds identify hernias?

Is there a role for ultrasound in identifying abdominal hernias?

Question submitted by:
Richard N. Nuttal, MD
Victoria, British Columbia

It is important to understand there are many different types of hernias and the diagnosis and management of these vary considerably.

A hernia results from a weakness in an investing musculofascial layer that allows protrusion of normally contained tissues through the weakened region.

Internal hernias are located within the limits of the peritoneal cavity (paraduodenal, pericecal, foramen of Winslow, pelvic, supravesical and intersigmoid); whereas, external abdominal hernias protrude beyond the limits of the peritoneal cavity.

For the most part, internal hernias will often require abdominal imaging (ultrasound and, more often, computerized tomography [CT] scan) for accurate localization and identification. External hernias, by their nature, are typically visible and exacerbated by position and intra-abdominal pressure (*i.e.*, Valsalva maneuver).

A careful history, combined with a meticulous physical examination technique is usually accurate in identifying and typing abdominal-wall herniation. In select cases, particularly those with complicated disease processes where physical examination may be limited (*i.e.*, morbidly obese), an ultrasound may be useful.

In these situations, however, a CT scan of the abdomen may be more beneficial, as the visualization of the defect in the peritoneal cavity is often visualized well with this modality.

Answered by:
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6. Down syndrome screening

Is first-trimester genetic screening (*i.e.*, serum testing, nuchal translucency) now a standard of care for women who are over 35 and at increased risk for pregnancy with Down syndrome?

Question submitted by:
B. Griffin, MD
Toronto, Ontario

There is no standard of care for this specific issue other than to provide women and couples with their options during a pregnancy.

The options currently available in Canada include:

- amniocentesis for women who are going to be over 35 at the expected date of delivery,
- maternal serum screening during the second trimester with a measurement of either two or three biochemical parameters in maternal serum and
- nuchal translucency screening, which can either be done alone or combined with markers in the second trimester or earlier markers during the first trimester.

Women who are over 35 at the expected date of delivery still have the options for nuchal translucency and/or maternal serum markers.

The advantage of amniocentesis is the test is diagnostic and essentially 100% accurate. Nuchal translucency and/or maternal serum markers are screening tests with a detection rate ranging from 40% to over 90%, based on the type of screening done. These screening tests are noninvasive, but the detection rate is not 100% and many women will be false positives with followup diagnostic testing by amniocentesis showing a normal karyotype.

In summary, none of the approaches are mandatory for pregnancy care, but it is mandatory women be offered whatever options are available.

Answered by:
Ross McLeod, MD, FRCPC, FCCMG
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Excellent GI tolerability[1-4*]

Most common side effects in clinical postmenopausal osteoporosis studies (ACTONEL vs. placebo): abdominal pain (11.8% vs. 9.5%), hypertension (10.6% vs. 9.4%) and joint problems (7.1% vs. 5.5%). The most common side effects in glucocorticoid osteoporosis studies were back (17.8% vs. 8.8%) and joint pain (24.7% vs. 14.7%).

ACTONEL 5 mg daily is indicated for the treatment and prevention of osteoporosis in postmenopausal women (PMO) and for the treatment and prevention of glucocorticoid-induced osteoporosis (GIO) in men and women. ACTONEL 35 mg Once-a-Week is indicated for the treatment of osteoporosis in postmenopausal women.

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Please refer to accompanying prescribing information for full dosing instructions and other important information.

* Randomized, double-blind, placebo-controlled study of 2,458 postmenopausal women with at least one vertebral fracture. All patients received 1 g/d calcium and, if baseline levels were low, 500 IU/d vitamin D.

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7. OCPs and the postpartum patient

When is it safe to start oral contraceptives in a postpartum patient?

Question submitted by:
Permjeet Dhanjal, MD
Winnipeg, Manitoba

Combined hormonal contraception can be started as soon as six weeks after delivery in breastfeeding women and sooner in non-breastfeeding women.

Progesterone-only hormonal contraception can also be started before the six-week interval, as the effects on milk let-down are related to the estrogenic component of the pill.

The 2004 Canadian Contraception Consensus contains a list of contraindications to oral contraceptive pills. The March 2004 issue of *The Society of Obstetricians and Gynecologists of Canada* published a section relating to combined hormonal contraception and progesterone-only hormonal contraception.

Answered by:
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8. Teens and SSRIs

Should SSRIs be used for anxious teenagers?

Question submitted by:
Helen Cvejic, MD
Montreal, Quebec

In trying to decide whether selective serotonin reuptake inhibitors (SSRIs) should be used, ask yourself:

Question	Ideal answers
1. Is this something other than anxiety?	No
2. Is the anxiety in addition to depression?	No
3. Has the teenager tried to relieve stress in other ways?	Yes
4. Have I tried behaviour modification therapy?	Yes
5. Has a computed body tomography scan been tried?	No/Yes
6. Is medication indicated?	Yes
7. Which anxiolytic is likely to cause the least problems?	SSRIs
8. Are SSRIs safe to use?	Yes in anxiety and, arguably, in depression.

Answered by:
Peter Matthews, MD, MB, BS, DPM, DCH, MRCPsy, FRCPC
Clinical professor of psychiatry
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Saskatoon, Saskatchewan

9. What's the significance of syphilis serology testing?

What is the significance of syphilis serology testing and the interpretations of levels to differentiate current infection from an old, quiescent infection one would not treat?

Question submitted by:
D. Spink, MD
Peterborough, ON

If serologic testing screening tests for syphilis (*i.e.*, rapid plasma reagent or venereal disease research laboratory), are found to be positive, the same specimen must be evaluated with a confirmatory test (*i.e., treponema pallidum* hemaglutination and fluorescent treponemal antibodies-absorption). If the confirmatory test is indeed positive, a diagnosis of syphilis is confirmed.

The key issue is to determine whether the patient has previously had syphilis and been treated. The following steps can then be followed in evaluating a patient who has a positive screening test with positive confirmatory tests:

1. When result is received, ask patients whether they have ever had syphilis and received treatment. If patients are unaware if they have ever had syphilis or been treated or if they have been treated, determine where they were treated and whether they received appropriate therapy.

2. If patients don't recollect having syphilis, it is important to determine the stage of disease. Primary syphilis is usually associated with a chancre and, with secondary syphilis, there are usually skin manifestations.

   With latent syphilis, there is no specific clinical manifestation and it may be prudent to perform a lumbar puncture, if any doubt exists. If a lumbar puncture screening test is nonreactive, patients can be deemed to have latent syphilis.

   The treatment for latent syphilis (greater than one year duration) is 1.2 million units of benzathine penicillin G administered into each buttock, once weekly for three successive weeks.

3. If the cerebrospinal fluid screening test is found to be positive, an aqueous crystalline penicillin G, three to four million units intravenously every four hours for 10 to14 days, would be warranted. It is important to detect and aggressively treat syphilis so as to prevent the long-term sequelae.

Additional information about the diagnosis and management of syphilis can be found in the most recent Canadian STD Guidelines (1998 edition).

Answered by:
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10. TSH and the elderly

In the absence of clear symptoms of hypothyroidism, at what level of TSH elevation do you initiate thyroid hormone replacement in elderly individuals?

Question submitted by:
Wayne Sheehan, MD
Rothesay, New Brunswick

Thyroid nodules are often encountered in clinical practice. Though the majority are benign lesions, about 5% may actually represent thyroid cancer.

It is important to determine whether the nodule is hyperfunctioning or malignant. Risks for cancer include age over 40, exposure to head and neck with radiation, family history, hoarse voice and enlarged neck nodes on physical exam.

Measurement of thyroid-stimulating hormone (TSH) level is helpful, as suppression suggests a nodule is hyperfunctioning. Hyperfunctioning solitary nodules carry a low risk of malignancy.

In the absence of TSH suppression, biopsy by fine-needle aspiration should be first-line investigation for a solitary nodule or a dominant nodule in a multinodular goiter. If cancerous, nodules need evaluation by an endocrinologist.

Ultrasonography is commonly used to assess thyroid structure and follow-up on thyroid nodules. Although some ultrasonographic features, such as punctate calcification and irregular or blurred margins, suggest papillary carcinoma, routine ultrasonographic studies rarely aid clinical decision-making.

Thyroid nodules are found incidentally during ultrasound of the neck for reasons unrelated to the thyroid gland. These "thyroid incidentalomas" are, in general, less than 1 cm to 1.5 cm in diameter and nonpalpable. They often pose a management problem for the clinician. However, because most of these nodules are benign, observation alone is recommended for those smaller than 1.5 cm, unless other features suggest malignancy.

Despite early suggestions that nodules in multinodular goiters are less likely to be malignant, more recent studies show the risk of malignancy in a dominant nodule in this condition is similar to that in a solitary nodule.

Thyroxine suppressive therapy may be used to treat benign nodules. Given increased risk of cardiac arrhythmia and evidence that subclinical hyperthyroidism can lead to loss of bone mass in post-menopausal women, TSH suppression should be used cautiously in older patients.

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Answered by:
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