Consultant's Corner

Practical Answers To Your Everyday Questions

This month—10 answers:

1. Bumpy lid referral

What should be done about small, benign-looking papules or bumps on the eyelid margin? Should the patient be referred to an ophthalmologist?

Question submitted by:
Bill Taylor, MD
Medicine Hat, Alberta

Because of the exposed nature of the lids and their morphology, up to 9% of all skin cancers arise in the eyelids and this fact must be born in mind when determining the etiology of any lid lesion, even if it appears benign.

Typical lesions, such as sudoriferous cysts, xanthelasma, seborrheic keratosis and the like, should be referred for routine excision to an ophthalmologist or oculoplastic surgeon because their location requires specialized techniques to prevent notching and distortion of th eyelid margin and trichiasis distortion and inturning of the eyelashes.

Basal cell carcinomas, which account for 90% of all eyelid malignancies, can, in their early stages, mimic a simple benign nevus, a sudoriferous cyst (cyst of Moll) or even an epidermal cyst. Only later do they become "rodent ulcers." Squamous cell carcinoma often develops at the mucocutaneous junction of the lower eyelid.

With rapid growth, change in colour, ulceration or bleeding, the patient should be referred urgently (a prior history of sun exposure or malignancy are invaluable pointers).

When evaluating lid lesions, always take an accurate history from the patient, always suspect malignancy in fair-skinned, elderly individuals who have been exposed to the sun, and do not forget Kaposi's sarcoma.

Answered by:
Malcolm Banks, MB, ChB, DO(Eng)
Ophthalmologist
Cypress Regional Hospital
Swift Current, Saskatchewan

2. How long will the epidural last?

When surgical approach is warranted in a case of ongoing low back pain due to multiple-disc herniation with moderate L3/L4 radiculopathy, how long will the epidural injection last in general?

Question submitted by:
Galbarg Araghi, MD
Toronto, Ontario

Injections are given for radicular pain. Patients with acute radiculopathy have a better response compared to patients with chronic symptoms. Very little evidence exists supporting the benefit of epidural injections for low back pain. Without fluoroscopic controls, studies have revealed misplacement of up to 40% of the caudal and 30% of the translaminar technique.

A disadvantage of the caudal route is that insufficient fluid passes above the L4-L5 level. The translaminar technique has the disadvantage that medication is usually more posterior to the thecal sac, as pathology is usually more anterior. Transforaminal injections may prove to be the most effective means of administrating epidural corticosteroids.

All of these techniques are generally very safe. Contraindications are listed in Table 1 and risks are listed in Table 2.

In my personal experience, epidural injections have had variable results in terms of efficacy and length of positive response, even in the same patient. It can vary from days to months. Two or three injections can be tried with a minimum interval of two weeks. No more than three to four injections per year are recommend because of the risk of osteoporosis.

Answered by:
François Cabana, MD
Orthopedic Surgeon
Centre Hospitalier Universitaire de Sherbrooke (CHUS)
Sherbrooke, Quebec

Table 1

Contraindications for epidural steroid injection

Absolute	• Local infection
	• Exogenous blood thinners: - Anticoagulant - Antiplatelet
	• Bleeding diathesis
	• Congestive heart failure
	• Uncontrolled diabetes mellitus
Relative	• Pain > one year
	• Psychosocial barriers to recovery

Table 2

Potential complications for epidural injections

- Allergic reaction
- Nausea
- Facial flushing
- Insomnia
- Fever
- Vasovagal syncope
- Pain radiation
- Neurologic deficit (usually transient)
- Myopathy
- Headache (non-positional)
- Superficial infection
- Epidural abcess
- Meningitis (aseptic, tuberculous)
- Sclerosing spinal pachymeningitis
- Arachnoiditis
- Spinal hematomas
- Intravascular injection (seizure, cardiac arrest)
- Anterior spinal artery thrombosis
- Abdominal distension
- Positional headache (subdural injection)

3. Smokers seeking birth control

What is the birth control of choice for women who are under 35 and smoke heavily?

Question submitted by:
William Potvin, MD
Carleton Place, Ontario

Although women under the age of 35 who smoke do not have a strict contraindication to combined oral contraceptives, other options are available for them that could be continued after their 35th birthday. These include non-hormonal options, such as an intrauterine device (IUD), condoms and spermicide, female condoms, a diaphragm, a cervical cap or a vaginal sponge.

Progesterone-only hormonal contraception would also be an acceptable option; for example, progesterone-only pills, injectable depot medroxyprogesterone acetate or progesterone containing IUDs.

Finally, if the woman has finished childbearing, consideration could be given to permanent contraception.

Answered by:
John Robertson, BSc, MD, CCFP, FRCS(C), FACOG
Obstetrician/Gynecologist
Chilliwack General Hospital
Chilliwack, British Columbia

Women under the age of 35 who smoke do not have a strict contraindication to combined OCPs.

4. Teeing off with CTS

For patients with carpal tunnel syndrome, does playing golf aggravate this condition or is it OK to continue playing golf?

Question submitted by:
Michael Leung, MD
Windsor, Ontario

Carpal tunnel syndrome (CTS) arises because of increased pressure on the median nerve through the carpal tunnel. Anything that creates undue pressure on the nerve can irritate it and create the typical symptoms of CTS.

Golf is an activity that may, or may not, aggravate the symptoms of CTS. It really depends on the pathophysiology of the development of the CTS in question. That said, any repetitive motion of the wrist that takes it alternately into deep flexion and then back to neutral/extension of the wrist will most likely cause further symptoms for the CTS wrist that has acute symptoms. For chronic sufferers, it may have no serious aggravating effect.

The other issue is the skill level of the golfer, the frequency of golfing, the extent of symptoms, their response to conservative treatment and their wrist strength. Many factors must be weighed before giving the patient the green light.

Answered by:
Howard Winston, MD, CCFP, FCFP, Dip. Sport Med. (CASM)
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Toronto, Ontario

Anything that creates undue pressure on the nerve can irritate it and create the typical symptoms of CTS.

5. Big prostate problems

Could a big prostate induce renal failure?

Question submitted by:
Claudia Petrescu, MD
Toronto, Ontario

Yes, a large (benign) prostate can cause renal failure. The renal failure is secondary to longstanding urinary retention. This in turn causes bilateral hydronephrosis, which, over time, will cause renal failure. It is because of this risk that serum creatinine should be measured in patients with longstanding urinary retention, and that urine output and renal function should be carefully monitored when such patients are catheterized.

Answered by:
Bryan Donnelly, MD, MSc, MCh, FRCSI, FRCSC
Staff Urologist
The Rockyview General Hospital
Calgary, Alberta

Serum creatinine should be measured in patients with longstanding urinary retention.

6. Antipsychotics for nausea?

Are newer antipsychotics, such as quetiapine, risperidone and olanzapine useful for controlling nausea in end-state cancer patients?

Question submitted by:
Tariq Saeed, MD
Mississauga, Ontario

Nausea is a challenging symptom to control in end-of-life cancer patients. Traditionally, metoclopramide, dimenhydramine, haloperidol and steroids have been the mainstays of treatment.

Newer drugs offer the possibility of treating several symptoms at one time. However, there is presently little clinical trial evidence that any are superior to the standard treatments.

Olanzapine has been described as having broad antiemetic properties.[1] In recent clinical trials, olanzapine has been found to have a positive response in reducing nausea with few, if any, side-effects.[2-4]

Currently, palliative care specialists use olanzapine as a third-line treatment, owing to limited clinical evidence and high cost.

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References
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4. Passik SD, Navari RM, Jung SH, et al: A phase I trial of olanzapine for the prevention of delayed emesis in cancer patients: A Hoosier Oncology Group study. Cancer Invest 2004; 22(3):383-8.

Answered by:
Susan M. MacDonald,
Associate Professor
Medicine and Family Medicine
Memorial University of Newfoundland
St. John's, Newfoundland

7. Workup for work-out-induced amenorrhea

An 18-year-old patient with a history of amenorrhea practices ballet four to five times a week with no other stressors. Her family history is negative for amenorrhea. What is the workup? What treatment options exist if all is normal?

Question submitted by:
Michele Dussault, MD
St. Bruno, Quebec

Exercise-induced amenorrhea is a diagnosis of exclusion. Rule out:

- serious illnesses,
- signs of androgen-excess or galactorrhea,
- medications, such as hormones, danazol, anti-psychotics and metoclopramide,
- neurologic changes,
- symptoms of menopause and
- history of obstetric trauma or curettage.

Examine the patient for normal thyroid, secondary sexual development and normal genitalia.

If the pregnancy test is negative with normal serum prolactin, follicle-stimulating hormone and thyroid-stimulating hormone, amenorrhea is the likely diagnosis.

Estrogen insufficiency can result in infertility, osteopenia, vaginal and breast atrophy.

This is not a problem of exercise alone, but of a relative decrease in calories. Referral to a nutritionist is strongly recommended. Document the patient's body mass index. Replace estrogen and progestin with the oral contraceptive pill, the patch, the ring or post-menopausal hormonal replacement, though these are not as effective as normal menses.

Baseline bone mineral density should be done for long-term followup. Calcium, 1,200 mg to 1,500 mg per day, is recommended. Bisphonates are not helpful.

In summary, after a history and physical, rule out pregnancy and other less-likely disorders, then educate, while maintaining estrogen as best you can.

Answered by:
Betsy Brydon, ND, FRCSC
Staff Teacher
University of Saskatchewan
Staff Physician
Regina Health District & Allan Blair Cancer Centre
Regina, Saksatchewan

8. Should hypertensives be on lipid-lowering drugs?

Should we put hypertensives with no other risk factors on lipid-lowering drugs?

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

I would answer "no"—not if no other risk factors exist. So far, the clinical trials have only included those at risk (Anglo-Scandinavian Cardiac Outcomes Trial, West of Scotland Study, Air Force/Texas Coronary Atherosclerosis Prevention Study) or those with disease. Thus, treating beyond the clinical data or beyond the guidelines would not be indicated.

Nonetheless, I would be vigilant in addressing global risk by a Framingham or other risk calculator. Remember that family history, metabolic syndrome, renal disease and microalbuminuria, among other factors, carry high cardiovascular risk and are not included in the usual risk engines, so, individualize every risk assessment.

Answered by:
Andrew Steele, MD, FRCPC
Active Staff
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Oshawa, Ontario

Treating beyond the clinical data or beyond the guidelines would not be indicated.

9. Ovarian cancer concerns

What findings on a pelvic ultrasound would cause concerns about ovarian cancer in pre- and post-menopausal women?

Question submitted by:
John Mazurka, MD
Hamilton, Ontario

Ovarian masses that are complex (meaning multiple cysts), or those with solid components, should be taken seriously. The presence of masses on both ovaries or free fluid (ascites) indicate a high suspicion of malignancy. Size is an important factor, since larger cysts are more worrisome. Even purely simple cysts should be referred if they reach 7 cm or persist over several menstrual cycles.

Menopausal status is the first most important risk factor when evaluating such a patient. It is important to remember that a premenopausal woman will form small functional cysts of 2 cm to 4 cm with each ovulation. Masses in a post-menopausal woman, however, are not functional and are more likely to represent neoplasm. These should be referred.

A premenopausal woman will form small functional cysts of 2 cm to 4 cm with each ovulation.

Answered by:
Lesa Dawson, MD, FRCSC
Assistant Professor
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Staff Physician
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10. Stopping and starting statins

Once a patient starts statins, can they ever be stopped? Are there serious consequences to abruptly stopping them?

Question submitted by:
George Lim, MD
Kingston, Ontario

Given the current ever-decreasing lipid level targets, it is becoming more difficult to achieve this by diet or lifestyle change alone, especially for high-risk patients, (*i.e.*, those with known cardiac disease or diabetes). However, lifestyle and diet counselling should still be the first steps.

The recent Treating to New Targets trial analysis demonstrated short-term discontinuation of statin therapy among stable cardiac patients did not lead to a clinically important increased risk of acute coronary syndromes.

However, we do not know if it is safe to permanently stop statins or discontinue them for an extended period of time, especially among patients in the acute setting. If statins have been stopped intentionally or unintentionally due to side-effects, an alternative statin that is better tolerated or a lower-dose statin with or without a cholesterol absorption inhibitor could be considered because therapy with a statin has been shown to be effective in primary and secondary prevention of cardiovascular disease.

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Answered by:
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