Consultant's Corner

Practical Answers To Your Everyday Questions

1. Recurrent Polyposis

Is there a preventive treatment for recurrent polyposis of the large bowel?

Question submitted by:
Dr. Chinh Nhan Nguyen
St. Leonard, Quebec

There is limited data on the prevention of initial or recurrent colorectal adenomas. The American College of Gastroenterology (ACG) recommends that patients consume a diet low in fat and high in fruits, vegetables and fiber. They should also maintain a normal body weight through regular exercise and calorie restriction, avoid smoking and excessive alcohol use. The only pharmacological recommendation by the ACG is dietary supplementation with 3 g of calcium carbonate.

Othermodalities have been studied to prevent polyp recurrence including ASA, NSAIDs or selenium supplementation, however, insufficient data exists to recommend these measures. Two large trials of COX-2 agents, celecoxib and rofecoxib, demonstrated significant reductions in adenomas, however, vascular events of strokes and MI were significantly higher in the groups randomized to the high doses of these drugs. Since COX-2 agents, NSAIDs and ASA have potential risk, they are not recommended for polyp prevention.

Answered by:

Dr. Jerry S. McGrath

2. Treating Thyroid Nodules

Should benign thyroid nodules be treated with thyroxine or not?

Question submitted by:
Dr. B. Lynn Crosbyl
Halifax, Nova Scotia

Suppressive therapy with exogenous thyroid hormone has been demonstrated to prevent growth of and/or decrease the size of thyroid nodules. However, a significant number of thyroid nodules remain stable over time without suppressive therapy. The risks of aggressive suppressive therapy include inducing a state of thyrotoxicosis, which is associated with an increased risk of atrial fibrillation and osteoporosis. Thus, the benefits of decreasing the growth of benign thyroid nodules need to be weighed against the risks of such therapy. In general, I avoid suppressive treatment in the elderly, or if the TSH is low/normal to begin with. In patients with high/normal or frankly elevated TSH levels, suppressive therapy to aim for a low/normal TSH is appropriate.

Answered by:

Dr. Hasnain Khandwala

Menopausal Hormone Therapy

3.

What are the current treatments for menopausal females according to most recent guidelines regarding menopausal hormone therapy?

Question submitted by:
Dr. Nathalie Leroux
Fenwick, Ontario

In the past, menopausal hormone therapy was prescribed for potential cardiac, cognitive and osteoporosis benefits. Its use has decreased after large prospective randomized trials demonstrated significant risk for CVD and breast cancer. Presently, systemic menopausal hormone therapy is used for symptomatic relief of severe menopausal symptoms such as hot flashes, night sweats and vaginal atrophy when non-hormonal agents are ineffective and the patient believes the benefits outweigh risks. It is used for as short a duration and as low a dose as is necessary. If the patient has her uterus, a progesterone agent is required to prevent endometrial cancer. A local estrogen based product should be used if she is suffering from symptoms related to vaginal atrophy. It can be used in the repertoire of agents to treat osteoporosis if the patient is suffering from severe menopausal symptoms. Menopausal hormone therapy is contraindicated in patients with venous thrombosis, coronary artery disease, severe liver disease and undiagnosed vaginal bleeding.

Answered by:

Dr. Cathy Popadiuk

Eczema on the Scalp

4.

What would you suggest for eczema on the scalp?

Question submitted by:
Dr. Anne Heyes
Vancouver, British Columbia

Eczema on the scalp can be a result of a variety of causes such as seborrheic dermatitis, atopic dermatitis, irritant contact dermatitis or contact allergy. Sorting this out as well as ruling out psoriasis, lice and other differential for scalp itching requires a careful dermatologic assessment. In terms of therapy topical steroids are usually the mainstay of therapy. For this purpose a variety of alcohol based lotions, gels, sprays and foams can be tried. As well, shampoos containing tar, zinc pyrithione, phenol and even cortisone can be added.

Answered by:

Dr. Scott Murray

Gallbladder Polyps

5. What is the proper follow-up for gallbladder polyps seen on ultrasound?

Question submitted by:
Dr. Stacey Saunders
Burin, Newfoundland

Gallbladder polyps are outgrowths of the mucosal wall usually found incidentally on ultrasound. They have been observed in 1.5% to 4.5% of gallbladders assessed by ultrasonography. In one report, no association was observed between the presence of polyps and the patient's age, sex, weight, number of pregnancies, or use of exogenous female hormones.

Gallbladder polyps are often asymptomatic but can be associated with biliary pain. The clinical significance relates largely to their malignant potential. The most common benign neoplastic lesion of the gallbladder is an adenoma while the most common benign non-neoplastic lesions are cholesterol polyps (cholesterolosis). Cholesterolosis is characterized by the accumulation of lipids in the mucosa of the gallbladder wall. It is a benign condition that is usually diagnosed incidentally on ultrasonography. In some patients cholesterolosis can lead to symptoms and complications similar to gallstones.

Adenomatous polyps of the gallbladder are benign epithelial tumors composed of cells resembling biliary tract plus epithelium. The frequency that adenomas progress to adenocarcinoma is unknown. The risk of malignancy of an adenoma is related to the size of the polyp. It is rare to see malignancy in a polyp < 1 cm. Polyps > 2 cm are almost always malignant. Polyps of 1 cm to 2 cm in size are possibly malignant.

The only effective treatment for either of these situations is cholecystectomy. If a patient has gallbladder polyps and concomitant gallstones a cholecystectomy is indicated. Cholecystectomy should also be recommended for patients who have biliary colic or pancreatitis in the setting of cholesterolosis and gallbladder polyps. Patients with non-specific dyspeptic symptoms should be managed conservatively and symptomatically. Lesions < 1 cm in diameter usually represent cholesterol polyps and can be followed by ultrasound in six months and then yearly. An increase in polyp size is an indication for cholecystectomy.

Answered by:
Dr. Jerry S. McGrath

Oral Allergy Syndrome

6. Is there a risk of anaphylaxis in oral allergy syndrome?

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

Patients with oral allergy syndrome typically describe itching of the oropharynx, palate and ear canals and mild swelling of the lips triggered by ingestion of fresh fruits (including tree nuts) or vegetables in pollen-sensitized individuals. These fresh fruits, vegetables and tree nuts contain proteins that are structurally homologous to major allergenic proteins in tree, grass or ragweed pollens. The structurally homologous proteins elicit immunologic cross-reactions that are IgE-mediated, giving rise to contact urticaria in the oropharynx. Only raw fruits or vegetables trigger these contact reactions, because the cross-reactive proteins are heat-labile and denatured by heating, cooking or even brief microwaving.

Diagnosis of oral allergy syndrome requires demonstration of specific IgE to pollen as well as to the corresponding fresh fruit, vegetable or nut. The diagnostic term "pollen-food allergy syndrome" more accurately describes the nature of the immunologic cross-reaction, whereby primary sensitization occurs to the pollen with subsequent development of cross-reactivity to the related food.

Systemic reactions to fresh fruits or vegetables are seen in < 10% of patients with oral allergy syndrome. Systemic manifestations are seen in locations remote from areas of direct contact with the offending food. Consequently, systemic reactions may involve:

- cutaneous manifestations (itchy skin, urticaria, angioedema, flushing),
- upper airway involement (rhinorrhea, nasal congestion, sneezing, symptoms of upper airway obstruction),
- lower airway involvement (wheezing, cough, chest tightness, dyspnea),
- GI (nausea, vomiting, cramps, diarrhea) or
- CV manifestations (palpitations, dizziness, lightheadedness).

In a review of 1,361 patients with oral allergy syndrome, 9% experienced symptoms outside of the GI tract, 3% experienced systemic symptoms with oral symptoms and 1.7% experienced anaphylactic shock.

Resource
1. Ortolani C, Pastorello EA, Farioli L, et al: IgE-Mediated Allergy From Vegetable Allergens. Ann Allergy 1993; 71(5):470-6.

Answered by:

Dr. Peter Vadas

Infected Ingrown Toenails

7. What treatment options are advised for infected ingrown toenails and are antibiotics indicated?

Question submitted by:
Dr. Roshan Dheda
Bradford, Ontario

Infected ingrown toenails result from an edge of the toenail growing into the periungual tissue which sometimes cause pain, infection and cellulitis. The first order of business is to remedy the impacted nail, either by inserting a piece of gauze under the nail edge to lift it out, or surgical resection of the nail. If there is an abscess, it should be drained.

Topical antibiotics such as fuscidic acid and mupirocin can help focal infections and Gram-positive directed antibiotics such as cephalexin may help for cellulitis. As well, frequent soaks with antiseptics or epsom salts may be soothing. In general, alleviation of the imbedded nail edge are the key to successful treatment.

Answered by:
Dr. Scott Murray

Hepatitis C

8. How are patients monitored after successful treatment of Hepatitis C (HCV) and can the virus return?

Question submitted by:
Dr. Roshan Dheda
Bradford, Ontario

In general, a sustained viral response is defined as the inability to detect HCV by polymerase chain reaction six months after the completion of treatment. Since treatment is relatively new, there has not been much published literature on the longer term follow-up of treatment responders, nor large scale evaluation of risk factors for relapse. It is fairly clear that most of those who remain free of detectable virus six months after treatment have probably eradicated the infection. Around 95% of these responders remain virus free in both blood and the liver during follow-up lasting over six years. Their liver histology improves, typically returning to normal, or nearly so, with resolution of inflammation and regression of fibrosis. There have been case reports of late relapse which appear to be precipitated by significant immunosuppression, such as with organ transplantation. There are no clear guidelines for the follow-up of successfully treated patients, but it is reasonable to check for viral RNA every six months for at least a few years.

Answered by:
Dr. Michael Libman

Dilated Cardiomyopathy

9.

What are the risk factors for dilated cardiomyopathy (DCM) and how should we screen for this?

Question submitted by:
Dr. Mary Ann Gorcsi
Brantford, Ontario

DCM is characterized by dilation and impaired contraction of the left ventricle or both ventricles. The patient may or may not present with overt heart failure symptoms. DCM can be due to a number of causes. Up to 50% of the cases have no clear identifiable cause and are considered as idiopathic. Common causes include:

- ischemic heart disease,
- myocarditis,
- infiltrative disease,
- peripartum cardiomyopathy,
- hypertension,
- HIV infection,
- connective tissue disorder,
- substance abuse (alcohol or cocaine) and
- chemotherapeutic agents (doxorubicin, trastuzumab).

Transthoracic ECHO is a useful non-invasive screening test to assess the ventricular size and function. A multiple gated acquisition scan is often employed to objectively quantify the ejection fraction.

Answered by:

Dr. Chi-Ming Chow

Asymptomatic Endometrial Polyps

10.

Do asymptomatic endometrial polyps in a perimenopausal or post-menopausal woman need to be removed?

Question submitted by:
Dr. Kathy Moore
Kingston, Ontario

Most women discover they have endometrial polyps following investigations for irregular bleeding or pain. Ultrasound and/or hysteroscopy may reveal the polyps, which are removed to address the symptom. The frequencies of pre-cancer and cancer in this situation are 6.7% and 2.2%, respectively. In asymptomatic premenopausal women the prevalence of polyps is 7.6% and 13% in asymptomatic post-menopausal women.

The risk of malignancy in asymptomatic endometrial polyps is very low. Large scale cohort studies of endometrial polyps in asymptomatic post-menopausal women show atypical hyperplastic polyps in 1.2% of patients and endometrial cancer in 0.1%. Wider polyps, > 18 mm in diameter, pose greater risk and should be removed.

Answered by:

Dr. Cathy Popadiuk

Medications for Pediatric BP

11. What type of BP medications are used in the pediatric population for high BP (excluding kidney disease)?

Question submitted by:
Dr. Melanie Arsenault
Rexton, New Brunswick

A wide variety of BP medications have been evaluated and are being used in children, but this has mostly been among children with kidney disease. However, there does appear to be a growing number of children with what appears to be primary hypertension (HTN) and thus the question of appropriate management is very germane. The management begins with accurate diagnosis; BP measurements need to be repeated as well as done using the appropriate sized BP cuff and the appropriate BP charts for age. If a child has documented high BP, then it is incumbent to determine if this is secondary to an organic cause.

In the case of secondary HTN, addressing the etiology of the HTN may be sufficient. In the absence of a secondary cause, the first therapy for childhood HTN is lifestyle (*i.e.*, exercise and diet) notably when the child in question has increased BMI. As well, reduction of caffeine intake—notably in "super sized" colas and other beverages—should be recommended.

If drug therapy is needed, this should be done under the guidance of a physician expert in the management of BP in children, typically a pediatric nephrologist. Calcium channel blockers such as nifedipine have been used in children with demonstrated efficacy and safety. There have been mixed reports with respect to β-blockers, with extended-release metoprolol being safe and relatively effective while carvedilol has been reported to be much less effective in children than in adults. This points to the need for consultation for the primary healthcare provider caring for a child with HTN.

Answered by:

Dr. Michael Rieder

Thrombasthenia

12. A patient has normal platelet count, normal INR, prothrombin time (PT), partial thromboplastin time (PTT). When should we think about thrombasthenia?

Question submitted by:
Dr. Nathalie Leroux
Fenwick, Ontario

When considering an underlying bleeding disorder with normal platelet count, INR and PTT, the requirement for further investigations is still based on clinical acumen supported by the degree and severity of bleeding and family history of the patient. A complete history of bleeding and bruising including hemostatic challenges such as dental procedures and surgeries and menstrual history, if applicable, are essential. Acquired causes of bleeding such as drugs, autoimmune or connective tissue disorders, liver and renal disease should be ruled out. A simple blood film may reveal platelets that are too small, too large, or with abnormal granulation that could potentially direct further investigations. A Von Willebrand screening test may also be considered in the appropriate patient. However, there are numerous hereditary bleeding disorders as a result of absent or abnormal platelet surface glycoproteins and absent or abnormal secretion of platelet granules. Further testing may include platelet aggregation studies, genetic testing and others.

Glanzmann thrombasthenia is a congenital absence or abnormality of platelet glycoprotein complex IIb-IIIa. This complex is essential for platelet function by binding to fibrinogen leading to platelet aggregation. Platelet numbers and morphology are normal, along with INR and PTT. However, a lifelong history of mucocutaneous bleeding with a positive history provides clues to an underlying hereditary disorder. Glanzmann thrombasthenia is just one of a multitude of such bleeding disorders.

Answered by:

Dr. Kang Howson-Jan and Dr. Cyrus Hsia

Orthotics for Children

13. Orthotics seem to come and go in popularity. Which kids really need them?

Question submitted by:
Dr. B. Lynn Crosby
Halifax, Nova Scotia

As noted, orthotics for children have had a waxing and waning popularity. Basically, the vast majority of children do not require orthotics or any form of specialized footwear. Specialized orthotoics are required for some children with specific orthopedic or other musculoskeletal problems. However, this decision should be made by a physician with special expertise in musculoskeletal or neurological problems in children.

Answered by:

Dr. Michael Rieder