Present Recommendations for the Treatment of Dog Bites

1. What are present recommendations for dog bites?

Question submitted by:
Dr. G.B. Molnar
Brampton, Ontario

Recommendations for the treatment of dog bites have not changed significantly for some time. The oral flora of dogs is fairly well covered by using penicillin or amoxicillin. Dogs, like cats, often carry *Pasteurella* in their mouths, rendering first-generation cephalosporins such as cefazolin or cephalexin, an inappropriate choice for empiric treatment. Superinfections of bites, as with any other open wound, is often caused by *Staphylococcus aureus*. Therefore, it may be wise to use a regimen which also covers this agent. Amoxicillin/clavulanate is often the easiest choice. There have been several reports of dogs being carriers of *methicillin-resistant staphylococcus aureus* (MRSA), and although empiric treatment of this agent is not generally needed, vigilance is necessary. The decision to treat with prophylactic antibiotics is generally made on a case-by-case basis when deciding whether a bite to the hand or face should be treated with prophylactic antibiotics. They are not proven to be beneficial, however the outcomes of infection following treatment in these areas can be poor. For this reason, many practitioners do choose to give prophylaxis in these cases. As well, there is a compromise to be made between cosmetic outcome and risk of infection when the decision on whether to close the wound is made. The need for rabies prophylaxis must obviously be assessed, and this is a good opportunity for giving a tetanus booster. Once a tetanus vaccination is offered, it also makes sense to offer pertussis vaccination.

Answered by:
Dr. Michael Libman

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When to Prescribe Infliximab

2.

A patient with ulcerative colitis that is on Salofalk, Asacol, and 6MP has been advised to take Infliximab. What are the pros and cons of this approach?

Question submitted by:
Dr. C. MacFarlane
Brandon, Manitoba

Infliximab is an anti–tumour necrosis factor α therapy. It is used to treat many inflammatory conditions, including rheumatoid arthritis, Crohn's disease, ulcerative colitis, ankylosing spondylitis, and psoriasis. Many randomized, controlled trials have confirmed the efficacy of infliximab in patients with inflammatory bowel disease who have been failed by conventional medical therapy. In the case of ulcerative colitis, this would be a patient like yours: one who has been failed by aminosalicylates (Asacol, Salofalk), has not been helped by the use of immunosuppressants (6MP or 6 mercaptopurine), and who may be steroid-dependent or refractory to steroids.

Infrequent but serious toxicities related to infliximab have occurred. The most serious are cancer, lymphoma, TB, and autoimmune disorders. These toxicities are rare, but they do sometimes occur. More commonly, patients are inflicted with more community-acquired infections, such as colds, sinusitis, bacterial pneumonia, *etc.* These need to be recognized and treated early.

The benefits to infliximab therapy generally outweigh the risks when prescribed to the appropriate patient. It has been shown that infliximab reduces and shortens hospital admissions, reduces steroid use and the need for surgery, improves quality of life, and induces mucosal healing.

Answered by:
Dr. Jerry S. McGrath

Does Pulling Out Hairs Stimulate More Hair Growth?

3.

Is it true that pulling out hairs (*i.e.* with tweezers) can stimulate more hair growth? If so, what is the best method to remove occasional single hairs around the areola?

Question submitted by:
Dr. Sandi C. Frank
Edmonton, Alberta

I know of no evidence that physical methods of hair removal: plucking, tweezing, shaving, waxing–increase subsequent hair growth. There is often an illusion that this is the case, as the hairs emerging after shaving may be coarser due to the blunt ends left behind. So repeat tweezing should not pose a problem.

However, a more permanent removal can be attempted through hair removal laser and electrolysis.

Answered by:
Dr. Scott Murray

Liver Screening for Type 2 Diabetics

4.

Should all type 2 diabetics be screened for liver disease?

Question submitted by:
Dr. Robert Fingerote
Thornhill, Ontario

I am assuming you are concerned about fatty liver and the effects of various medications on liver function. The prevalence of fatty liver is increased in patients with type 2 diabetes given that a significant percentage of them are overweight and obese. A significant number of them are also on various kinds of medications, which can either potentially cause liver dysfunction (statins, *etc,*) or be contraindicated in the presence of significant liver disease (metformin). I am not aware of any guidelines that specifically address the issue of screening for liver disease in patients with diabetes, but obtaining a set of liver enzymes at baseline and periodically thereafter (every three to six months) seems reasonable. If there is significant elevation in the liver enzymes, then a referral to a hepatologist may be appropriate for further investigations.

Answered by:
Dr. Hasnain Khandwala

Treatment of Asymptomatic Bacteriuria During Pregnancy

5.

How long should we treat asymptomatic bacteriuria in pregnancy?

Question submitted by:
Dr. Svitlana Lukin
Thornhill, Ontario

Asymptomatic bacteriuria (AB) in pregnancy should be treated to prevent associated risks for preterm delivery, perinatal mortality, and progression to pyelonephritis in the parturient. Usually, a short course of antibiotics suffices, from three to seven days, depending on the antibiotic. The urine should be tested one week later to confirm cure and should be repeated monthly. Where AB becomes a repetitive problem with relapse, suppressive therapy is used for the duration of the pregnancy. Nitrofurantoin (NF), penicillins, cephalosporins, and trimethoprim (TM) are prescribed p.o., q.h.s. NF and TM should be avoided in the first trimester, due to risk of birth defects. Near term, NF has caused rare haemolytic anemia and sulfa drugs kernicterus in the newborn. These drugs should, thus, be avoided at this time and other alternatives used.

Answered by:
Dr. Cathy Popadiuk

When to Order ASOT

6. When should one order ASOT?

Question submitted by:
Dr. Donald Weshoy
Weymouth, Nova Scotia

The Antistreptolysin O titre (ASOT) should reflect recent infection with Group A Streptococcus. It is often ordered with anti-streptococcal DNAase, which should provide similar information. These are very old tests, and review of the older literature shows sensitivity, and specificity, which are modest, at best. Furthermore, current automated versions of these assays often have poor or inadequate data to demonstrate reliable correlations with the older, well studied assays. That being said, the test is usually requested when one is trying to establish a diagnosis of a post-streptococcal syndrome, usually glomerulonephritis or rheumatic fever. ASOT is still part of the recommended diagnostic criteria for the latter. In theory, low ASOT rules out recent non-dermatologic Group A Streptococcus infection.

Answered by:
Dr. Michael Libman

Differentiating Between Bipolar and Borderline Personality Disorder

7.

Can you differentiate between bipolar and borderline personality disorder?

Question submitted by:
Dr. Edwin J Franczak
Toronto, Ontario

Borderline personality disorder and bipolar share a lot of the similar hallmark diagnostic criterion. One may even think of them as being on the same clinical spectrum, but in reality they are two very distinct entities with two different scopes and modalities of treatment. An effective approach for the clinician to take is to make an analysis of the patient's history and to take the time to separate the mood component from the behavioural component. An analogy I use is schizophrenia versus schizoaffective. Schizoaffective patients have a more prevalent mood component, whereas schizophrenic patients experience more positive symptoms in general.

Borderline personality disorder in and of itself does not have the marked highs and lows associated with bipolar type 1 but may look clinically like bipolar type 2, with outburst, mood lability, anxious periods and depression, plus unpredictable behaviour. Change in eating habits, friends, sexual behaviour, along with other changes, may be noted. All of these are on a similar spectrum as bipolar disorder. With bipolar disorder, there is about a 50% risk of the patient having a concurrent substance abuse disorder. The numbers in borderline personality disorder are just as high. In addition, concurrent medications, herbals and disease states must always be considered, as there is a high prevalence of self-medication which presents its own challenges, including alterations of behaviour, serotonin syndrome, and much more.

Mood stabilizers may offer benefits in borderline personality disorder, as may SSRI agents, with the concern and caveat that activation may occur. Not unlike bipolar disorder, where there is a high propensity towards activation with highly selective SSRI agents, activation may occur in borderline personality disorder, and be compounded by the condition itself, especially in younger patients under 25-years-of-age, where an enhanced propensity to commit suicide is of concern when prescribing serotonergic acting agents.

The treatment modalities include medications and psychological interventions for both disorders. Adequate psychotherapy may be of benefit, depending on the root cause analysis. For example, in anxiety, one may consider use of behavioural, cognitive, rational emotive behaviour, and rational behaviour.

The first two therapies are often combined and delivered as cognitive behavioral therapy (CBT). For borderline personality disorder, more emphasis is placed on psychological components and root cause analysis, whereas medications are emphasized for bipolarity and Axis I.

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Answered by:
Professor Joel Lamoure

Managing Itchy Skin During Pregnancy

8.

How do you manage the problem of itchy skin in pregnant women?

Question submitted by:
Dr. Soheir Atalla
Brossard, Québec

Itchy skin in pregnancy results from hormonal estrogen effects and the physical skin changes associated with stretching. Avoiding situations that dry the skin, such as hot baths and showers, and taking measures to stay cool in hot weather climates can all help prevent the skin from drying out. Applying a gentle moisturizer after bathing, while the skin is moist, may be soothing, as are compounds with aloe vera or calamine lotion. Mild unscented soaps and a warm bath with oatmeal or bicarbonate are also suggested. If the itching is associated with a rash or blistering of the skin, abnormal liver signs, or continues to worsen despite the aforementioned measures, the patient should be referred to an obstetrician to rule out more serious conditions.

Answered by:
Dr. Cathy Popadiuk

Screening in the Elderly for Pernicious Anemia

9.

Is it worthwhile to screen the elderly for pernicious anemia (in absence of symptoms)?

Question submitted by:
Dr. F. Foley
Toronto, Ontario

It is certainly worthwhile to screen for vitamin B12 deficiency in elderly patients who have anemia or macrocytosis without any other explanation, irrespective of symptoms. Untreated vitamin B12 deficiency can lead to significant complications. Pernicious anemia is a cause of vitamin B12 deficiency and can only be diagnosed with a Schilling test. The Schilling test is becoming extremely difficult to access; hence, in practice, this is often not done.

Answered by:
Dr. Cyrus Hsia and
Dr. Kang Howson-Jan

Treatment for Post-nasal Drip

10.

What is the best successful treatment for post-nasal drip?

Question submitted by:
Dr. Rafeeq Kagee
Cochrane, Alberta

Post-nasal drip (PND), is also known as post-nasal discharge or upper airway cough syndrome. It occurs when mucus accumulates in the back of the nose and throat. It is frequently caused by allergies. It can also be due to rhinitis, sinusitis, laryngopharyngeal reflux, or a disorder of swallowing (such as an esophageal motility disorder). Elevated levels of estrogen hormones in birth control pills, or due to pregnancy, can cause post-nasal drip as well. The following symptoms may be associated with post-nasal drip:

- Runny nose (due to mucus flow)
- Frequent spitting
- Itching or throat tickling
- Constant swallowing
- Nasal congestion
- Chronic sore throat
- Halitosis
- Snorting
- Constant throat clearing
- Dysphonia
- Coughing

Treatments include saline nasal solutions, anti-allergies, antibiotics, decongestants, and/or acid control medication. Allergy medications, such as antihistamines, decongestants, nasal steroids, or a combinations of these, may be prescribed. Oral steroids may be used over a short period of time. However, we must be careful; when those commercials say that a product gives you "dry mouth," you can bet it will give you a dry nose and throat too!

Answered by:
Dr. Ted Tewfik

11. Immunity to Hepatitis B Infection

Patients with negative HBsAg, positive anti–HBcore, negative anti-HBs. Are they Hept B carriers? Are they contagious?

Question submitted by:
Dr. Benjamin Choy
Markham, Ontario

Studies have shown that most of these people are in fact immune to post hepatitis B infection and that their anti-HBs response has simply faded to below the limit of detection with current tests. This can be proven by showing a strong booster response to a single dose of vaccine. A few, however, do in fact have mild ongoing infection, with very small amounts of HBsAg present, and viral DNA present by nucleic acid amplification testing. Finally, a few are in the so-called "window period," the time during acute infection when the surface antigen is disappearing while antibody is increasing. This can be confirmed by testing for Anti-HBcore IgM, or more definitively by showing the appearance of anti-HBs a couple of weeks later.

Answered by:
Dr. Michael Libman

12. The New Biomarker ColonSentry Test Measure

Can you comment on the new biomarker ColonSentry?

Question submitted by:
Dr. Ken Armstrong
Niagara Falls, Ontario

The ColonSentry test measures the expression of seven genes. These genes serve as biomarkers to detect colorectal cancer. Interpretation of these seven biomarkers can be used to identify patients who have an increased current risk of colorectal cancer. It is recommended that individuals with an increased risk of colorectal cancer based on this test should have a colonoscopy. Decreased risk does not rule out the presence of the disease. Since ColonSentry assesses the patient's current risk of colon cancer based only on these seven genes, and does not rule out the presence of cancer, I would not recommend it.

Answered by:
Dr. Jerry S. McGrath

Optimal Time to Repair an Acute Nasal Fracture

13. When is the optimal time to repair an acute nasal fracture?

Question submitted by:
Dr. Roshan Dheda
Bradford, Ontario

Nasal fractures rank third in incidence, after fractures of the clavicle and wrist. Palpation of the external nose for tenderness, stability, or mobility is the most reliable step for diagnosing a fracture of the nasal pyramid. Radiographic studies are only reliable when correlated with physical examination. Photographic documentation is an important part of medico-legal documentation.

The treatment options are either closed or open reduction. The best opportunity for successful management is within the first three hours after trauma. If this is not possible, many authors suggest that reduction is performed within three to seven days. Others believe that waiting until the swelling has diminished, and surgery is convenient for the patient, causes no harm.

The indications for closed reduction are:

- Unilateral or bilateral fracture of the nasal bones
- Fracture of the nasal-septal complex with pyramid deviation less than half the width of the bridge

The indications for open reduction are:

- Excessive fracture dislocation
- Fracture of the nasal-septum complex with pyramid deviation more than half the width of the bridge
- Fracture-dislocation of the caudal septum
- Open septal fracture
- Persistent deformity after closed reduction
- Combined deformities of the septum and alar cartilage
- History of recent nasal surgery

Answered by:
Dr. Ted Tewfik

Best Agents for Treating Psoriasis of the Scalp

14. What are the best shampoos for psoriasis of the scalp?

Question submitted by:
Dr. P.I Slowey
Brockville, Ontario

As a general rule, I find therapeutic agents much more effective when applied directly to the scalp and left on (as in gels, pomades or lotions), rather than quickly washed out. However, there is some benefit to using a salicylic acid shampoo for descaling. Tar shampoos relieve itch quite a bit, and newer steroid-containing shampoos can reduce itching. The common co-existence of seborrhea with psoriasis (sebopsoriasis), may lead to a beneficial result when using antiyeast shampoos, such as ciclopirox, ketoconazole, zinc pyrithione, or selenium sulpha shampoos.

Answered by:
Dr. Scott Murray

Alternative to BDEPQ for Patient with Insomnia and on Antidepressants

15.

What is the best alternative to benzodiazepines in a patient on anti-depressants, but who is still suffering from insomnia?

Question submitted by:
Dr. Catherine Cameron
Toronto, Ontario

This is a question that addresses many facets of a patient's situation. Effective root cause analysis is required to determine why the patient is experiencing the insomnia. For example, antidepressants of the serotonin selective reuptake (SSRI) class or serotonin-norepinephrine reuptake (SNRI) class are well documented to unmask bipolar disorder in patients. This unmasked bipolarity and switch in poles from depression to mania/hypomania may clinically present as insomnia. Depression and generalized anxiety disorder often coexist and the antidepressant may not be the ideal choice, nor would optimizing the dose to control the anxiety component. Also, in line with the United States Sequenced Treatment Alternatives to Relieve Depression (STAR-D) trial, optimum therapy duration was over 14 weeks, so the pharmacochronology is critical.

From a pharmaco-chronology option, some SSRI or SNRI agents themselves may cause activation, which is not uncommon (up to 20% of patients) and manifests as agitation and sleep changes. Switching agents, or the time of day they are delivered, may control the insomnia.

Switching agents, or non-adherence itself, may present with insomnia, as agents used at higher doses, for longer lengths of time, with no active metabolites may cause side-effects when stopped. These side-efects mimic the acronym FINISH: fever (flu like symptoms), irritability, insomnia, sensory or movement changes, and headache.

As such, there are many iatrogenic causes of insomnia. Furthermore, medical causes of insomnia must be ruled out, for example: alzheimer's or dementia. In patients where benzodiazepines are to be used with caution (substance abuse history, allergies, chronic obstructive sleep disorder, and electro-convulsive therapy, to name a few), the buspirone (5 to 10 mg t.i.d.), or even better, a low dose atypical antipsychotic (quetiapine 25 to 50 mg h.s. or trazodone 12.5 to 50 mg h.s.) may be considered.

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Answered by:
Professor Joel Lamoure