Prescribing Clopidogrel Post Angioplasty

1.

Is there a correct duration to prescribe clopidogrel post angioplasty?

Question submitted by:
Dr. C. Cunningham
Vernon, British Columbia

The optimal duration of dual ASA/oral P2Y12 receptor antagonist therapy, post-stenting, particularly among drug-eluting stent (DES) recipients, is unknown. Registry data suggests a protective effect of continuing dual antiplatelet therapy beyond 24 months, but two recent randomized clinical trials did not show any benefit to continuing to take clopidogrel beyond the duration of one year.

The current Canadian guidelines recommend the following:

1) All patients who have undergone percutaneous intervention (PCI) with a bare-metal stent (BMS) should be given clopidogrel 75 mg daily in addition to ASA 75 to 162 mg daily for at least one month and up to 12 months in the absence of an excessive risk of bleeding.
2) All patients who have undergone PCI with DES implantation should be given clopidogrel 75 mg daily in addition to ASA 75 to 162 mg daily for 12 months.
3) For all post-PCI patients, indefinite therapy with ASA 75 to 162 mg daily is recommended, regardless of the type of stent.
4) Dual antiplatelet therapy with ASA 75 to 162 mg daily and clopidogrel 75 mg daily may be considered beyond one year in patients with acute coronary syndrome (ACS) who receive a BMS or DES provided their risk of bleeding is low.
5) For patients with ACS who undergo stent implantation and have an increased risk of stent thrombosis (*e.g.*, STEMI, history of diabetes mellitus, or prior documented stent thrombosis), prasugrel 10 mg daily may be considered in addition to ASA 75 to 162 mg daily for 12 months. Prasugrel should be avoided in patients who have an increased bleeding risk, are likely to undergo coronary artery bypass graft (CABG) within seven days, have a history of stroke or TIA, are aged ≥ 75 years, or weigh < 60 kg.

Reference
1. Bell DB, Roussin A, Cartier R, *et al*: The Use of Antiplatelet Therapy in the Outpatient Setting: Canadian Cardiovascular Society Guidelines Executive Summary. Can Cardiol 2011; 27(2): 208–221.

Answered by:
Dr. Brent Heilbron

URI Symptoms and Edematous Uvula: Likely Infectious Agent?

2.

What is the likely infectious agent in the case of an adult with URI symptoms and an edematous uvula?

Question submitted by:
Dr. G. Steffens
Barrie, Ontario

There is nothing particularly pathognomonic about the involvement of the uvula in cases of various infections involving nearby structures, such as the tonsils or the soft palate. Ordinary streptococcal pharyngitis often includes edema of the uvula. Common enteroviral pharyngeal infections, such as herpangina and hand, foot, and mouth disease often have small ulcers on the tonsils, uvula, and soft palate. Sometimes, depending on the nature of the inoculation, the herpes simplex virus can manifest primarily in the posterior pharynx, including the uvula. It has been said that diphtheria should be suspected when tonsillar membranes also involve the uvula, but this is an exceedingly rare diagnosis in North America.

Answered by:
Dr. Michael Libman

Distinguishing Between Aphthous and Other Mouth Ulcers

3.

How do you distinguish an aphthous ulcer from other mouth ulcers?

Question submitted by:
Dr. Denis Cheung
Ottawa, Ontario

Apthous ulcers are usually recurrent, minimally symptomatic, and nonscarring (minor); they may also be larger and scarring (Sutton's) or grouped and painful (herpetiform). These relapsing lesions can be difficult to treat and are usually found in adults over 20. Signs of other causes of mouth ulcers, such as inflammatory bowel disease, viral diseases, connective tissue disease, or Behçet's disease should be sought; red flags include nausea, vomiting, abdominal pain, diarrhea, sore throat, fever, malaise, myalgias, arthralgias, headache, cough, swollen or painful lymphadenopathy, generalized rash, and genital or conjunctival lesions.

Answered by:
Dr. Scott Murray

Diabetes Mellitus Onset and Peripheral Neuropathy Symptoms

4.

After the onset of diabetes mellitus, how long does it take to have symptoms of peripheral neuropathy?

Question submitted by:
Dr. R. Kunjukrishnan, Ottawa, Ontario

Diabetes is one of the most common causes of neuropathy. Clinical and subclinical neuropathy has been estimated to occur in 10 to 100% of diabetic patients, depending upon the diagnostic criteria and patient populations examined. Generally, prevalence depends on the duration of disease, and it is estimated that approximately 50% of patients with diabetes will eventually develop neuropathy.

In one study, over 4,400 patients with diabetes were followed for over 25 years, and the onset of neuropathy correlated positively with the duration of diabetes; after 25 years, 50% of patients had neuropathy. In this study, neuropathy was defined as decreased sensation in the feet and depressed or absent ankle reflexes.

In another study, the overall prevalence of diabetic neuropathy was 28.5%. There was a correlation with disease duration such that the prevalence reached 44% in patients between 70- and 79-years-of-age.

The occurrence of neuropathy generally depends on the duration of disease, as well as the degree of glycemic control achieved. Patients with poor control of diabetes tend to have an earlier onset of neuropathy, and it tends to be more severe as well.

Answered by:
Dr. Hasnain Khandwala

Distinguishing Between Genital Warts and Vulvar Papillomatosis

5.

How do you distinguish between genital warts and vulvar papillomatosis?

Question submitted by:
Dr. L. Kiefer
Toronto, Ontario

Vulvar papillomatosis (VP) is a normal anatomic variant of the vulva seen in 1% of women. It is characterized by fine, smooth, uniform filiform papules seen symmetrically along the vulvar vestibule — the inner surface of both labia minora. This benign condition is asymptomatic and diagnosis is made on visual inspection and stability of the lesions over time. Human papillomavirus (HPV) does not cause VP, but VP may be associated with a coexisting HPV infection.

Genital warts are caused by HPV types 6 and 11. They are benign lesions that are not confined to the labia minora, are not symmetrical, and can be seen anywhere on the vulva. The lesions are more variable in appearance and can have larger, cauliflower-type projections, which can be firm in consistency, and disturbing to patients.

On colposcopic evaluation, when 3 to 5% acetic acid is applied to the vulva, genital warts typically whiten, whereas, with VP, there is usually no whitening, and the area appears pink.

Answered by:
Dr. Cathy Popadiuk

Smoking Cessation Benefits

6.

Are the atherogenesis problems due to smoking reversable (*e.g.*, a heavy smoker who stopped 10 years prior to evaluating [framingham])?

Question submitted by:
Dr. J.D. Elltoft
Niagara-on-the-Lake, Ontario

Smoking cessation has many health benefits, including a reduction in myocardial infarction. The usually quoted statistics are that smokers have about twice the risk of coronary heart disease as non-smokers. After one year of smoking cessation, this excessive risk is minimized by half, and it disappears after 15 years.[1]

Reference
1. US Department of Health and Human Services. The Health Benefits of Smoking Cessation. US Department of Health and Human Services. Public Health Service. Center for Disease Control. Center for Chronic Disease Prevention and Health Promotion. Office on Smoking and Health. DHHS Publication No.(CDC) 1990;90–8416. http://profiles.nlm.nih.gov/ps/access/NNBBCV.pdf. Accessed October 13, 2011.

Answered by:
Dr. Thomas W. Wilson

7. Asthma Diagnosis in Young Patients

How young can a patient be when diagnosed with asthma?

Question submitted by:
Dr. Ann Vaidya
Calgary, Alberta

The diagnosis of asthma is always problematic without spirometry. As a result, the diagnosis in children under six-years-of-age may not be secure, but it is likely to be accompanied by typical symptoms, such as nighttime cough and wheeze, shortness of breath and wheezing after exertion, and episodic shortness of breath and wheezing associated with an upper respiratory tract infection. The diagnosis of asthma at an early age is more likely when a family history of the condition exists, especially a maternal history of asthma, and when the child is atopic with features such as eczema. In general, the earlier the age, the more likely the diagnosis will ultimately prove to be wrong. The reason for this is that there are other wheezing syndromes acquired in infancy and early childhood that will gradually resolve as the child approaches school-going age. Nevertheless, it is better to err on the side of diagnosing asthma and provide appropriate treatment, rather than leaving the child to develop chest deformity and impaired growth, which were so common in the days before inhaled corticosteroids.

Answered by:
Dr. Robert Cowie

8. Taking Pictures of Pigmented Lesions to Track Changes

What to do with a patient who has various brown moles on his/her back? Is it recommended that the patient take pictures to help the doctor identify any changes?

Question submitted by:
Dr. Isis Guirguis
Mississauga, Ontario

If there is any question about the status of pigmented lesions, a qualified examiner should assess the patient. The physician can advise whether serial photographs may be helpful in the ongoing follow-up of the lesions. Certainly, a concerned patient who suspects change to the pigmented lesions may wish to show such images to the physician, but a proper, in-office skin examination by an expert is still needed. In my experience, the value of photographs pales in comparison to proper examination and dermatoscopic evaluation.

Answered by:
Dr. Scott Murray

Management of Fetal Alcohol Spectrum Disorder

9.

According to the latest research, what are the best approaches in the management of fetal alcohol spectrum disorder (FASD)?

Question submitted by:
Dr. Sarah Cook
Yellowknife,
North West Territories

There are a wide range of problems associated with fetal alcohol spectrum disorder (FASD), which include effects on intelligence, attention, learning, memory, language, motor abilities, and behaviour. These can be major problems, and, as can be imagined, existing therapies are somewhat limited. Best management appears to be through early intervention, while delaying intervention can be associated with a higher incidence for at-risk behaviours with potentially dire consequences. Management is typically best conducted by a multidisciplinary team expert in the management of FASD. Some of the goals are to develop self-worth, establish behavioural standards, assist in developing independence, and teach the child how to make acceptable decisions. Given the many problems — and limited therapies — associated with FASD, the importance of prevention (both primary prevention through public education and secondary prevention targeting women who are known to have issues with alcohol consumption) is emphasized. The Canadian Paediatric Society recently published an excellent statement reviewing these issues (http://www.cps.ca/english/statements/II/ii02-01.htm).

Answered by:
Dr. Michael Rieder

HPV Vaccination Boosters and Indications for Males

10.

What is the length of time quadrivalent human papillomavirus recombinant vaccine will provide protection? Should it be used in males?

Question submitted by:
Dr. John Fitzsimons
Bradford, Ontario

At this time, it is premature to speculate on how often HPV vaccines will have to be boosted. It is clear that the antibody titres decline slowly with time, and we presume this will ultimately be reflected by declining protection against infection. However, we will have to await long-term follow-up studies to get solid information on both the decline of protection against infection over time and the effectiveness of booster doses. Given the cost of these vaccines, there will also have to be cost-benefit studies on booster vaccinations from the public heath viewpoint. The entire issue becomes even more complicated when we take into consideration various future scenarios for cervical cancer screening programs (*e.g.,* PAP testing).

As far as vaccinating males goes, we do know that the vaccine is safe in boys and has already been approved for use in boys in many jurisdictions. Of course, vaccinating boys is likely to further reduce infections in girls, which would heighten the primary goal of preventing cervical cancer. There is also good evidence that the vaccine can prevent penile cancer, a rare disease, and anal cancer and its precursors — a not so rare disease, especially among those boys who will go on to engage in anal sex. Again, from a public health viewpoint, the cost-effectiveness of vaccinating boys will be somewhat more expensive than vaccinating girls and will generate debate.

Answered by:
Dr. Michael Libman

Neutropenia Finding on a Routine Blood Draw

11.

Should anything be done about a neutropenia finding on a routine blood draw? The patient feels well and there are no other findings.

Question submitted by:
Dr. Gail Dangoor
Thornhill, Ontario

Asymptomatic neutropenia can have a variety of explanations. Persons of African descent and those belonging to certain ethnic groups that hail from the Middle East have benign ethnic neutropenia with low leukocyte and neutrophil counts. The neutropenia tends to be mild and asymptomatic in such individuals. More severe neutropenia can be seen in patients with congenital neutropenia, cyclic neutropenia, chronic idiopathic neutropenia (overlapping with autoimmune), drug-associated neutropenia, and a variety of infections that cause transient neutropenia. In primary practice, the last two of these should be ruled out before other causes are considered. The clinical picture and the absence of recurrent bacterial infections of any kind should be indicative of the significance of the laboratory abnormality.

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

Risks Associated with Cardiac CT Angiogram

12. What is the radiation risk associated with a patient receiving a cardiac CT angiogram? How does this compare with other modalities, such as chest x-ray or nuclear imaging?

Question submitted by:
Dr. Sheldon Lewis
Windsor, Ontario

There is a small, but definite, radiation risk to many medical procedures. The table below shows average radiation exposures for several common procedures.[1] The United States Environmental Protection Agency estimates the background absorbed radiation to be 300 mrem per year and advises that the incremental exposure be no more than 100 mrem per year.[2] This, of course, is conservative. Known immediate health effects of radiation vary from certain death at 200,000 mrem to transient nausea at 5,000 mrem.[3] The estimated single dose LD50 (at which 50% of exposed people would die) is 40,000 mrem. Long-term effects, particularly cancer incidence, are more difficult to estimate. Many authorities accept that the minimum single radiation dose to cause a detectable increase in cancer is 1,000 to 5,000 mrem.[4] Cumulative radiation exposure effects over many years are even more difficult to estimate, but are likely higher at 5,000 to 10,000 mrem.

Procedure	Radiation Exposure (mrem)*
Chest x-ray (PA and lateral)	6
Dental panoramic	9
Hip (bilateral)	80
Heart Technetium (99mTc) sestimibi stress	585
Chest CT	800
Coronary angiography	460–1,580
Coronary CT angiography	100–2,000
Coronary angioplasty	750–5,700

** milliRoentgen equivalent man (mrem); to convert to milliSieverts (mSv) divide by 100*

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2. Raff GL, Goldstein JA: Coronary Angiography by Computed Tomography: Coronary Imaging Evolves. J Am Coll Cardiol 2007; 49(18):1830–1833.
3. http://www.epa.gov/radiation/understand/health_effects.html#whatlimits: Accessed March 25, 2012.
4. Brenner DJ, Doll R, Goodhead DT, *et al*: Cancer Risks Attributable to Low Doses of Ionizing Radiation: Assessing What We Really Know. Proc Natl Acad Sci USA 2003; 100(24):13761–13766.

Answered by:
Dr. Thomas W. Wilson

Macerated Nipples in a Newly Nursing Mother

13.

How do you treat macerated and infected nipples in a newly nursing mother without using lanolin?

Question submitted by:
Dr. Nivine Elgwaidy
Swan River, Manitoba

Macerated and infected nipples in a nursing mother result from an incorrect latch between the baby and the breast, exacerbated by repetitive nursing. Important in the treatment of this condition is assuring that the latch is correct and comfortable. For affected nipples, warm saline soaks can clean and soothe the area. Applying cool, soaked tea bags in between feedings can also be soothing. Should such symptomatic efforts not address the problem and the nipples continue to be sore and infected, the mother can apply plain polysporin cream to the nipples after feeding. If the nipples still appear infected and macerated, a combination ointment composed of a weak steroid, an antibiotic, and an antifungal can be used. A popular combination sold as "Newman's Nipple Ointment" is composed of 2% mupirocin ointment, betamethasone 0.1% ointment, and miconazole powder for 2% concentration. This combination ointment has been found to be very effective in addressing infected macerated nipples.

Answered by:

Dr. Cathy Popadiuk and
Corinne Bursey, International Board-Certified Lactation Consultant

In-office Treatment of Common Warts

14.

For common warts, what do you advise GPs to use for in-office treatment?

Question submitted by:
Dr. M. Krieger
Toronto, Ontario

Topical salicylic acid preparations (up to 50%), liquid nitrogen, or cantharidine can all be useful to have on hand. Also, pamphlets on the natural history of warts and their tendency to self-resolve can be helpful in assisting patients when they are considering their options for the management of these warts.

Answered by:
Dr. Scott Murray

IGRA Testing vs. Mantoux Screening

15.

I have heard of a blood test to replace the Mantoux screening test. Is this clinically available? How useful is it?

Question submitted by:
Dr. Bhoama Bhayane
London, Ontario

There is a relatively new type of test that can replace the Mantoux test in many cases. This test is known as an interferon gamma release assay (IGRA) and is marketed under a couple of different brand names. The main advantages of this type of test are that it is a blood test and, thus, does not necessitate another visit for test reading, and the fact that it does not cross react with the BCG vaccine and most other nontuberculous mycobacteria makes results easier to interpret. The Mantoux test also requires a certain expertise to administer and interpret, which is not the case for the IGRA. The main downside to the IGRA is that it is technically complex, and, thus, it is not available in all diagnostic laboratories. It is also relatively expensive, although the cost may not be that different when the indirect and medical costs associated with the return visit for the Mantoux are taken into account. The two tests tend to correlate well; however, there are some discrepant results that are not easily explained. The most helpful aspect of IGRA testing is when a patient has a positive Mantoux, but it is unclear whether this result is due to exposure to tuberculosis or is a result of prior BCG vaccination.

Answered by:
Dr. Michael Libman

Itchy Ear Canal Treatment

16. What is the best way to treat itchy ear canals?

Question submitted by:
Dr. Hawkins
Kelowna, British Columbia

Itchy ears have many causes. The different etiological factors can include cerumen impaction, infectious agents (bacterial or fungal), allergic conditions, dermatological conditions, and other miscellaneous causes, such as insects or foreign bodies.

As any other medical condition, the treatment depends on the causative factor:

- Cerumen impaction is usually removed by syringing with warm water, unless there is a tympanic membrane perforation. In that case, microscopic removal is advised. The instillation of mineral, olive, or baby oil by the patient once or twice weekly is advisable. This will facilitate the natural flow of wax to the outside of the ear, making its removal less painful. Cotton swab use for ear cleaning should be discouraged
- Bacterial infection of the external auditory canal (EAC) manifests itself as itching (pruritus). Examination reveals erythema and swelling of the EAC skin. Treatment with ointments is restricted by the difficulty of their application. The use of ear drops containing antibiotics and dexamethasone is often curative. The dexamethasone acts as a universal anti-inflammatory agent. Otomycosis or fungal external otitis, is another cause of itching. Pruritus is the most common symptom. *Aspergillus* species and *Candida albicans* are the most common fungi
- Dermatological diseases (psoriasis, eczema, or seborrheic dermatitis) can also affect the EAC. Significant obstruction and scaling can cause conductive deafness. Certain shampoos or hairsprays can cause itching and irritation of the ear canals
- Insects can enter the EAC. They cause buzzing and itching, and they mostly enter during sleep. Their removal is usually accomplished using warm water. If it is difficult to get them out, a visit to a specialist is advised
- Other causes of pruritus include trauma from the use of instruments to clean out the EAC, the presence of a foreign body, congential narowing of the EAC, or systemic diseases (in particular diabetes mellitus) should be ruled out

Answered by:
Dr. Ted Tewfik

When to Switch from Homogeneous to 1 or 2% Milk

17.

Whole homogeneous milk is suggested after one-year-of-age. When can parents switch to 1 or 2%? Does the size of the child matter?

Question submitted by:
Dr. Marc Sawyer, Kitchener, Ontario

This is a good question. The Canadian Paediatric Society recommends homogenized milk for children from ages one to two, after which time 1 to 2% milk is recommended. While historically the recommendations have been to switch from breast milk or formula to homogenized milk, the fact is that 75% of Canadian homes use 1 or 2% milk. Thus, this would mean that the family of a child transitioning to milk from formula or breast milk might need to purchase two different types of milk, which may be problematic for some families. The belief that dietary fats are required for brain development is the reason why homogenized milk is used in children from ages one to two. However, for children in developed countries, there is no evidence supporting this given the amount of fat that children obtain from other sources. It should be noted that the American Academy of Pediatrics has stated that using 1 or 2% milk when switching from breast feeding or formula is acceptable, notably for children who are overweight.

Answered by:
Dr. Michael Rieder

How Common is Metformin-related Lactic Acidosis?

18. How common is serious metformin-related lactic acidosis, and should we be using it in cardiac patients?

Question submitted by:
Dr. M. Gagliardi
Sidney, British Columbia

Metformin is an effective first-line oral hypoglycemic agent used since the 1950s (available in Canada since 1980) in the treatment of type 2 diabetes mellitus for its insulin-sensitizing benefit. When taken as directed, metformin is effective, inexpensive, and safe, standing alone as the only oral hypoglycemic agent with trial data demonstrating reduced mortality. The UK Prospective Diabetes Study (UKPDS) showed a substantial beneficial effect of metformin therapy on CVD outcomes, with a 36% relative risk reduction in all cause mortality and a 39% relative risk reduction in myocardial infarction.[1] While there may be a theoretical risk of lactic acidosis when metformin is used in the context of contrast dye exposure from renal stress, such as following cardiac catheterization, this risk is exceedingly rare and should not deter physicians from making use of this important agent. There is no evidence from prospective comparative trials or from observational cohort studies that metformin is associated with an increased risk of lactic acidosis or with increased levels of lactate compared to other antihyperglycemic treatments.[2] Nonetheless, it remains common practice to avoid metformin 48 hours before coronary angiography. Until a randomized clinical trial can establish the precise incidence of metformin-induced lactic acidosis in this setting, this seems like a prudent precaution.

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Answered by:
Dr. Theodore Fenske

Long-term Effects Associated with Chronic PPI Use

19.

What, if any, are the long-term nutritional issues associated with chronic (> one year) use of PPI?

Question submitted by:
Dr. Carolyn Rogers
Burkington, Ontario

Given the physiological suppression of gastric parietal H,K-ATPase and potent suppression of hydrogen ion secretion, there are theoretical concerns of long-term usage with respect to nutritional deficiencies dependant on a low pH for gastrointestinal absorption, which include iron, vitamin B12, and magnesium. An association between long-term PPI use and reduced vitamin B12 levels, as well as an increased frequency of vitamin B12 deficiency, has been identified in several small, nonrandomized retrospective studies and case reports. However, the clinical significance of these findings has not been demonstrated within the existing literature. As such, routine screening in most patients is not supported by the existing data, although assessment in the malnourished or elderly may be reasonable. Some interesting data has suggested that chronic PPI therapy may facilitate clinically significant iron deficiency in patients in iron overload states (such as hemochromatosis). There is no prospective data demonstrating an association between clinically significant iron deficiency and long-term PPI treatment, and routine screening is not supported by the existing data.

Recent case series data has identified a potential association with hypomagnesemia. The majority (< 30) of the cases identified were using PPI therapy for more than two years. Concomitant hypokalemia and hypocalcemia were commonly identified with cases of severe hypomagnesemia, in addition to severe associated symptoms. Withdrawl and the reintroduction of PPI therapy correlated with changes in the serum magnesium levels, although the physiological mechanism has not been clearly defined. Although rare, a low index of suspicion for patients presenting with such electrolytic derangements in the context of chronic PPI therapy must be maintained.

Resource

1. Sheen E, Triadafilopoulos G: Adverse Effects of Long-term Proton Pump Inhibitor Therapy. Dig Dis Sci 2011; 56(4):931–950.

Answered by:
Dr. Theodore Xenodemetropoulos

Clinician-administered Scales for Depression

20. What patient self-reported and/or clinician-administered scales are recommended for response to pharmacological treatment in depression?

Question submitted by:
Dr. Bhooma Bhayand
London, Ontario

The three most commonly used clinician-administered scales recommended for measuring a patient's response to pharmacological treatment include the Hamilton Rating Scale for Depression (HAM-D), the Clinical Global Impressions (CGI) Scale, and the Montgomery-Asberg Depression Rating Scale (MADRS). By using these scales initially and through follow-up, physicians can systematically measure progress and work together with the patient to modify therapy and improve functionality.

The HAM-D scale is a multiple-choice questionnaire consisting of 21 questions that physicians can use to rate the severity of a patient's depression after interviewing and observing the patient. Specifically, the questionnaire rates the severity of depressive symptoms, such as low mood, insomnia, agitation, anxiety, and weight loss. While it is often referred to as the gold standard and is one of the most commonly used scales in evidence-based medicine and studies, there has been increased criticism that there are flaws with respect to the conceptual basis of the scale. Therefore, there is some question regarding its reliability as a test instrument.

The CGI Scale is another standardized assessment tool that allows physicians to rate the severity of their patient's depression, its change over time, and the efficacy of medication (taking into account the patient's clinical condition and the severity of side effects). The advantage of using the CGI Scale in a clinical setting is that it usually only takes a few minutes to complete the scale after conducting the patient interview.

Finally, the MADRS can be employed by clinicians to measure the severity of depressive episodes in patients with mood disorders. This scale consists of 10 questions and is often used as an adjunct to the HAM-D. The advantage of this scale is that it is more sensitive to the changes brought on by antidepressants and other medications than can be determined using the HAM-D. That being said, there has been a high degree of statistical correlation between scores on both the MADRS and HAM-D scales.

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Answered by:
Dr. Joel Lamoure
Contributor:
Professor Jessica Stovel

Irritated, Noninflamed, Patchy, White Tongue

21. What are some causes of irritated, noninflamed, patchy, white tongue?

Question submitted by:
Dr. Steve Choi
Oakville, Ontario

White plaques can be caused by a wide range of disorders — from benign to malignant. Leukoedema, lichen planus, bite marks, *Candida*, psoriasis, lupus, white sponge nevus, oral hairy leukoplakia, and geographic tongue are all conditions that should be considered. The changes may point to squamous cell cancer, which should always be considered if an alternative diagnosis can not be made. This should especially be considered in a patient who is a smoker.

Answered by:
Dr. Scott Murray

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UNESCO Chair in Bioethics

Canadian UNESCO-Affiliated Bioethics Unit to the International UNESCO Chairs in Bioethics Awards Dr. Joel Lamoure the UNESCO Chair, Canada to the Supervision of The Canadian Network

Joel Lamoure
RPh, BScPhm, DD, FASCP, OSM
UNESCO Chair, Canada

A UNESCO Chair designation in medical bioethics was established in 2001, as a result of published research under Professor Carmi from 1996 and 2001. This research focused on the provision and outcomes of medical bioethics education. Secondary to this research, a UNESCO International Chair position was created for a UNESCO Chair in Medical Bioethics. An international network was created from interested and supporting universities across the world, with each of the 29 signatory countries being designated a UNESCO Medical Education Bioethics University, with a corresponding National Network and Chief/Lead for their respective country. In 2009, Canada became a signatory to this initiative. Western University enjoys collaboration with other bioethics universities, including Harvard in the United States, Tokyo Medical University in Japan, and the University of Haifa in Israel to name a few.

These networks have been tasked with determining the status of medical education deliverables in bioethics in their country, including quality, placement, sustainability and robustness within the medical curriculum.

On August 22, 2012, the UNESCO Chair awarded Dr. Joel Lamoure to the supervision of The Canadian Network. He is a critical care pharmacist and Associate Professor in the Department of Psychiatry at Western University. Dr. Lamoure also serves as a scientist with Lawson Health Research Institute and surveyor with Accreditation Canada.

For more information on the International Network of the UNESCO Chair in Bioethics, please visit http://www.unesco-chair-bioethics.org/