Is There an Alternative?
Homeopathy in Medicine

Originally scheduled for the University of Toronto's **Primary Care Today** conference (May 10, 2003)—rescheduled (October 4, 2003)
by **Mel Borins**, MD, CCFP, FCFP

1. What are the main principles of homeopathy?

- A substance that causes symptoms in a healthy person can be used to treat those same symptoms in a sick person.
- The more diluted a remedy solution becomes, the more potent it is. Dilutions where there are no molecules of the original substance left are said to be most potent.
- Remedies that match not only the symptoms of the disease, but also the makeup of the patient, are most effective.

2. Does homeopathy work?

There are a number of randomly-assigned, double-blind, controlled trials that show homeopathy is useful for childhood diarrhea, allergic rhinitis, asthma, and post-operative ileus. A number of meta-analyses state that homeopathy is significantly more effective than placebo.

For an in-depth look at homeopathy, please go to page 93.

3. What are the problems with doing scientific evaluations of homeopathy?

- There is no one remedy for any particular symptom.
- The emotional and physical makeup of the patient are important, therefore, one remedy may fit one person's constitution, but can be inappropriate for another.
- It's hard to form a control group.

4. Can homeopathic medicines be used to immunize?

There is no proof that homeopathic medicines are adequate to protect children against measles, rubella, polio, pertussis, *etc*. Modern and clinically proven immunizations should not be abandoned.

Face to Face: Aggression in the Elderly

1. How do I choose an antipsychotic?

- Although haloperidol is usually preferred in an acute situation, atypical antipsychotics are otherwise preferred in the elderly because of greater tolerability.
- Consider underlying diagnosis, and if LBD or Parkinson's disease are present, quetiapine or clozapine may be best tolerated (or acetylcholinesterase inhibitors).
- For other patients with dementia and no EPS or history of falls, then risperidone may be chosen, unless a more sedating antipsychotic is needed to control evening and nighttime aggression.
- If symptomatic orthostatic dizziness develops or is already present, then consider risperidone. For other considerations, see page 106, Table 4.

2. Should I stop an atypical antipsychotic if it has been effective?

Recommendations and experience suggest that in a subset of patients, antipsychotics are not beneficial and may even cause worsening of behavioural symptoms. Even those with documented benefit may be able to taper or discontinue the medication after several months. Guidelines suggest trials to discontinue or taper the antipsychotics once to twice a year in most circumstances, unless the patient has repeated, failed attempts.

As presented at the **Southern Alberta Regional CME** conference (April 24, 2003)
by **Adrienne F. Cohen**, MD, BSc, FRCPC

3. When should I avoid atypical antipsychotics or exercise caution?

- When patients have cardiovascular disease
- In people with diabetes, or those with risk factors for developing diabetes (olanzapine and clozapine)
- When using benzodiazepines (exercise caution with clozapine)
- In patients with LBD
- In patients with other Parkinsonian syndromes
- In patients with prolonged QT (not with atypical antipsychotics available in Canada)
- In patients with history of seizure (avoid clozapine)
- In patients with history of falls or mobility disturbances
- In patients with dyslipidemia/high triglycerides
- In patients with urinary retention, glaucoma, and other symptoms exacerbated by anticholinergic activity (especially with clozapine)

For an in-depth look at aggression in the elderly, please go to page 103.

Good Bones, Good Health, Good Life
A Look at Osteoporosis

Based on an article by **Monique Camerlain**, MD, FRCPC

1. How is bone strength measured?

Currently, there is no accurate measure of overall bone strength and bone quality. BMD is used as a proxy measure and accounts for 70% of bone strength.

2. What are some of the risk factors for osteoporosis?

- Age > 65 years
- Vertebral compression fracture
- Fragility fracture after age 40
- Family history of osteoporotic fracture
- Primary hyperparathyroidism
- Hypogonadism
- Early menopause
- Osteopenia seen on X-ray
- Malabsorption syndrome

For an in-depth look at osteoporosis, please go to page 112.

3. Who should be tested for osteoporosis?

According to the OSC:

- All post-menopausal women and men over 50 should be assessed for risk factors of osteoporosis.
- BMD testing is appropriate for targeted case finding among people under 65 and for all women 65 years or older because of the high risk of osteoporotic fracture.

4. Which medications are most effective in treatment?

Only alendronate and risedronate reduce the risk of both vertebral and non-vertebral fractures. Their new weekly formulations are also preferred by patients and improve compliance. New agents, such as ibandronate and zoledronate, offer effectiveness with less frequent dosing.

What Says It's Polycystic Ovary Syndrome?

1. Who should be tested for PCOS?

Some of the major diagnositic criteria are:

- Chronic anovulation
- Hyperandrogenemia
- Clinical signs of hyperandrogenemia
- Exclusion of other etiologies
- Strong family history of diabetes

2. What does the PCOS ovary look like?

The PCOS ovary has the appearance of multiple small follicles on the outer edge of the ovary. An ultrasound examination of the ovary illustrates a minimum of 10 echo-free cysts ranging from 2 mm to 8 mm in diameter.

For an in-depth look at PCOS, please go to page 77.

As presented at the University of Saskatchewan's **49th Annual Pediatrics, Obstetrics & Gynecology** conference (February 2003)
by **Donna R. Chizen**, BSc, MD, FRCSC

3. What are the features of hyperandrogenism?

- Clinically, it is expressed as hirsutism, acne, and androgen-dependent alopecia.
- Biochemically, it is characterized by mildly elevated serum concentrations of androgens, including testosterone, DHEAS, and 17-OHP.

4. What is the main treatment for PCOS?

- Lifestyle modifications are key to treatment. Women with PCOS are encouraged to exercise regularly and modify their diets.
- Insulin-sensitizing agents, such as metformin or a thiazolidinedione (such as rosiglitazone), could potentially decrease serum androgen levels, improve ovulation, and decrease plasma triglycerides.
- With anovulation, progestin should be used cyclically to prevent the development of hyperplasia and adenocarcinoma.