1. What's the value of evidence-based medicine?

Evidence-based medicine does not apply to all patients. Agree or disagree?

Submitted by:
Terrence R. Carscadden, MD
Lively, Ontario

I must admit, this really is the ultimate question, because, as general practitioners, we deal with this debate on a daily basis.

We would all like to believe we practise evidence-based medicine. However, the reality is, we often go with our gut feelings. Of course, our decisions are based on our experience, the opinions of our peers and colleagues, and perhaps most importantly, our patients desires. All of these factors have a great influence on our practise of the "art" of medicine.

I have been privileged to sit on several guideline committees. The evidence is not always grade A, therefore, I believe evidence-based medicine does not apply to all patients.

Answered by:
Stephen Coyle, MD, MBBS, LMCC, CMO
Assistant lecturer, University of Manitoba
Winnipeg, Manitoba

This month's topics:

2. What is the latest on ascites?

What are the current management and investigation strategies for ascites?

Submitted by:
Phillip Fingrut, MD, MB, ChB
Toronto, Ontario

Successful treatment of ascites depends on an accurate diagnosis of its cause. All patients should be investigated for causes, even when cirrhosis is suspected.

The most important diagnosis to rule out is spontaneous bacterial peritonitis (SBP). An ascitic fluid neutrophil count of > 250 polymorphonuclear cells/mm^3 is diagnostic of SBP.

The diagnosis of ascites secondary to cirrhosis is made using the serum ascites albumin gradient (SAAG = serum albumin – ascitic albumin).

Diuretics are the mainstay for treatment of ascites due to cirrhosis and portal hypertension. Secondary hyperaldosteronism is a major factor promoting renal sodium retention; therefore, the use of a potassium-sparring diuretics, such as spironolactone or amiloride, achieves a better natriuresis than loop diuretics. The recommended initial dose of spironolactone is 100 mg to 200 mg once daily. The dosage may be increased to 400 mg/day. A common side-effect of spironolactone is gynecomastia.

Loop diuretics, such as furosemide, are used as an adjunct to spironolactone therapy. The initial oral dose of furosemide is 20 mg to 40 mg daily, and is generally adjusted upward every few days to a maximum of 160 mg/day.

The mobilization of ascites is best assessed by daily weighing of the patient. The rate of weight loss should not exceed 0.5 kg/day in the absence of edema, or 1 kg/day in the presence of edema.

Electrolytes and creatinine should be monitored frequently at the initiation of treatment, as well as during any change in diuretic dose.

Answered by:
Jill McDermid MD, FRCPC
Hepatology research fellow, University of Alberta
Edmonton, Alberta

Robert Bailey, MD, ABIM, FRCPC
Clinical professor of medicine, University of Alberta
Edmonton, Alberta

3. What is the link between nuts and diverticulitis?

Do patients with diverticulitis really need to avoid nuts and seeds?

Submitted by:
Stephen Sullivan, MD, FRCP
Victoria, British Columbia

There is no clinical evidence that nuts and seeds increase the risk of diverticulitis. The main cause of diverticulitis is the buildup of hard fecaliths made up of dry solid material. These fecaliths then erode the diverticulum and perforate. Cereal fibre, on the other hand, traps water and forms soft mushy stools, which do not form these fecaliths or perforate the bowel.

In short, there is no evidence that seeds and nuts should be restricted, provided a high-fibre diet is consumed.

Answered by:
Khursheed Jeejeebhoy, MBBS, PhD, FRCP, FRCPC
Professor, faculty of medicine
University of Toronto
Toronto, Ontario

4. Treating endometriosis

What is the best way to treat endometriosis?

Submitted by:
Marichal Binns, MD, CCFP
Edmonton, Alberta

Surgical and medical therapy are both effective. The surgical procedure will be dependent on the need to preserve fertility, surgeon skill, and patient preference. Most surgeons will begin with conservative surgery aimed at restoring normal anatomy by excising, scarring, and destroying endometrial implants. Most surgeries will be done using laparoscopic techniques, although laparatomy is used in severe infiltrating endometriosis.

The destruction of endometriosis can be done by electrocautery dessication, laser ablation, or resection by sharp dissection, but there are no randomized trials that have determined the best way. Sharp dissection is the present choice and has the advantage of providing a pathologic diagnosis.

Endometriomas should be dealt with surgically, as they do not respond to medical management. Usually the cyst will be drained and stripped or ablated, although no studies have looked at the best management protocol.

Infiltrating endometriosis is best excised. If bowel involvement occurs, the treatment may include a bowel resection.

Pain relief following surgery is less clear. With minimal disease, 10% to 20% of women will have returned to preoperative pain levels within one year.

In contrast, definitive surgeries, such as hysterectomy and bilateral salpingoophorectomy have a 90% success rate in curing pain.

Also note that leaving ovaries in will increase the chance of pain 5.8 times, but will not require exogenous estrogen replacement in young women.

Answered by:
Magali Robert, MD, BSc, FRCSC
Assistant professor, University of Calgary
Calgary, Alberta

5. Is anorexia a psychosis?

We are treating anorexia nervosa with acute psychotics, but as far as I know, no one has come out and said that anorexia is a psychosis. Why not?

Submitted by:
Michel L'Écuyer, MD, CCFP
Ottawa, Ontario

Antipsychotic medications are not approved as a treatment for anorexia nervosa, nor has anorexia nervosa been described as a psychotic disorder. The body image distortion encountered in anorexia is qualified as a delusional proportion, but not actually a full-fledged delusion; it fluctuates with the affective state of the patient and it does improve with proper nutrition and weight gain.

At the present time, some clinicians are using the new atypical antipsychotics, such as olanzapine, on a trial basis, due to their effect in facilitating weight gain. However, this use is considered off-label, as antipsychotics have not been approved for this indication.

In addition to facilitating weight gain, the new atypical antipsychotics tend to reduce inner tension and obsessive thinking; both of these effects are beneficial in anorexia nervosa.

Trials evaluating olanzapine in the treatment of anorexia nervosa are ongoing.

Answered by:
Hany Bissada, MD, FRCP(C)
Director, Regional Centre for the Treatment of Eating Disorders
The Ottawa Hospital
Ottawa, Ontario

6. What is the best way to deal with mono?

What is the best treatment for mononucleosis? Does treatment with amoxicillin cause penicillin allergy?

Submitted by:
Gordon Milne, MD
Thunder Bay, Ontario

There is no specific treatment that is effective against infectious mononucleosis, which is caused by Epstein-Barr virus. There are antiviral medications available with some activity in vitro against Epstein-Barr virus, but controlled trials have not shown any clinical benefit.

Treatment is, therefore, symptomatic, consisting mostly of antipyretics and analgesics for pharyngitis (which may be severe). There is reasonable evidence that a short course of steroids may be of benefit for pharyngitis severe enough to cause upper airway obstruction or for autoimmune complications.

Recent studies have shown marginal short-term benefit of steroids for non-obstructive pharyngitis.

More than 30 years ago, it was noted that 90% to 100% of patients with mononucleosis given ampicillin developed an itchy rash typical of a hypersensitivity reaction; however, this does not appear to represent a true allergy to beta-lactams and, generally, does not recur with subsequent re-exposure to the drug. Dx

Answered by:
Michael Libman, MD, FRCPC
Associate professor, McGill University
Montreal, Quebec