Answers to your questions from our medical experts

1. Canadian Recommendations for Mammography

What are the current Canadian recommendations for mammography in women 40- to 49-years-old?

Submitted by: David Dannenbaum, MD, Montreal, Quebec

Current Canadian guidelines suggest that women between 40- and 49-years-old should get a clinical breast exam by a healthcare provider every two years. Women 40- to 49-years-old, especially selective populations (*i.e.*, women with a first-degree family history of breast cancer), should have the opportunity to access mammography. However, women should be counselled about the risks (increased false positive, more biopsies), as there is controversy regarding the degree of benefit in screening asymptomatic women without a positive family history in this age group. Breast cancer screening through mammography has been shown to have less sensitive, due to denser breast tissue, in this age group compared to older women. Tumour growth may be more rapid in younger women (40- to 49-years-old); therefore, in women choosing to participate in mammographic screening, the recommended interval is one year.

Resource

1. Ringash J, Canadian Task Force on Preventive Health Care: Preventive Health Care, 2001 Update: Screening Mammography Among Women Aged 40-49 Years At Average Risk Of Breast Cancer. CMAJ 2001; 164(4):469-76.

Answered by: Dr. Victoria Davis

2. Risk of Bleeding While on Warfarin

I have more cardiac patients on warfarin and enteric coated ASA. What is the reason? Is there a risk of bleeding?

Submitted by: Anonymous

Patients usually require ASA therapy for the treatment of coronary artery disease or cerebrovascular disease. Warfarin is added for very specific and often co-existing CV conditions, such as atrial fibrillation, valvular heart disease and thromboembolic disease. Each medication has specific benefits and works through different mechanisms and patients often require the use of both treatments. The risk of bleeding with combined therapy is obviously higher than with either medication alone, in fact up 1.5- to two-fold increase in the risk of major bleeding defined as requiring transfusions, in a critical site like intracranial, or fatal (while warfarin alone has a bleeding risk of up to 3% per year).[1]

Reference

1. Dentali F, Douketis JD, Lim W, et al: Combined Aspirin-Oral Anticoagulant Therapy Compared With Oral Anticoagulant Therapy Alone Among Patients At Risk For Cardiovascular Disease: A Meta-Analysis Of Randomized Trials. Arch Intern Med 2007; 167(2):117-24.

Answered by: Dr. Richard Sheppard

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3. Drug-Free Holidays for Depressed Patients

Is there any place for giving depressed patients (after they have recovered from depression and are stable) drug-free holidays, as is sometimes currently done in the treatment of hypertensive patients?

Submitted by: Azad S. Guron, MD, Stephenville, Newfoundland

The successful treatment of the patients with major depressive disorders consists of an acute phase lasting a minimum of six to eight weeks, during which a remission is induced. After achieving remission, the patient enters the continuation phase, which usually lasts 16 to 20 weeks, during which time the remission is consolidated and relapse is prevented. Patients, who are susceptible for recurrence of subsequent major depressive episodes, should enter the maintenance phase of treatment. In general, the same antidepressant doses are employed during the maintenance phase as they were used during the prior acute and continuation phases.

There is strong evidence that those with three or more episodes of major depression should receive maintenance phase treatment and, indeed, even at five years, maintenance medication has prophylactic efficacy. When the decision is made to discontinue maintenance pharmacotherapy, it is best to taper the medication over the course of at least seven weeks. It is worth noting that for some patients, maintenance treatment may be required indefinitely. The literature does not support drug-free holidays in the treatment of affective disorders.

Resource

1. American Psychiatric Association: Practice Guidelines for the Treatment of Psychiatric Disorders American Psychiatric Association: Compedium 2006. American Psychiatric Publishing, 2006. p.1-1612.

Answered by: Dr. Hany Bissada

The successful treatment of the patients with major depressive disorders consists of an acute phase lasting a minimum of six to eight weeks, during which a remission is induced.

4. Infectious Mononucleosis

How long is infectious mononucleosis infectious to others?

Submitted by: Anonymous

Transmission of the Epstein-Barr virus (EBV) requires intimate contact with saliva from an infected person. Transmission of the virus through the airborne route does not normally occur. The incubation period is usually four to six weeks. Those with infectious mononucleosis may be able to spread the virus for a period of weeks. It is important to note that specific precautions or isolation procedures are not recommended since the virus may also be found in the saliva of healthy people. Of note, healthy persons can carry and spread the virus intermittently for life. These persons usually serve as a primary reservoir for person-to-person transmission. It is for this reason that it is virtually impossible to prevent transmission of the virus.

Answered by: Dr. John M. Embil

5. C-Reactive Protein

Is C-reactive protein (CRP) useful in following patients as a cardiac marker?

Submitted by: Charles Lynde, MD, Markham, Ontario

As the name suggests, high sensitivity CRP (hs–CRP) is different than CRP, a smaller elevation is detected. It is the hs-CRP that has recently been studied in clinical trials and added to recent dyslipidemia guidelines. The measurement of hs-CRP is recommended for intermediate risk patients according to the Framingham Risk Score for men > 50-years-old and women > 60-years-old if their LDL-C is < 3.5 mmol/L. If their hs-CRP is elevated, than consideration should be made for statin treatment to lower LDL-C < 2.0 mmol/L according to the 2009 Canadian dyslipidemia guidelines. Acute illness may elevate hs-CRP and therefore should likely be measured when the illness resolves.

Answered by: Dr. Vincent Woo

6. Initial Tests for Hirsutism

? What are the initial tests to order in a patient with hirsutism?

Submitted by: Balbina Russillo, MD, Montreal, Quebec

Outside of a good history and physical exam, few tests are needed in most women. Consider checking serum testosterone and dehydroepiandrosterone sulfate (DHEA-S) especially if moderate or severe hirsutism, or hirsutism of any degree if it is sudden in onset and rapidly progressive, or associated with irregular menses, obesity, or evidence of virilization. Check prolactin if irregular menses. The goal is to identify women with potentially serious disorders (*e.g.*, androgen-secreting tumours), but also to identify women with disorders such as polycystic ovary syndrome (PCOS), who have important menstrual and metabolic concerns in addition to their hirsutism. If there is a family history or high risk ethnic background, check 17-OH progesterone also. Order an adrenal CT scan to look for an adrenal androgen-secreting tumour if serum DHEA-S concentrations ≥ 13.6 µmol/L and a transvaginal ultrasound if serum total testosterone concentration is ≥ 5.2 nmol/L. If PCOS, also need to check fasting glucose, lipids +/- 75 g oral glucose tolerance test.

Answered by: Dr. Ally P. H. Prebtani

7. Folic Acid in Depression

? Any benefit to using folic acid in depression?

Submitted by: Edwin J. Franczak, MD, Scarborough, Ontario

Depressed individuals with low serum folate and B12 levels and elevated serum homocysteine levels often fail to respond to conventional antidepressants. Elevated serum homocysteine is a marker for folate, B6 and B12 deficiencies and is a risk factor for Alzheimer's disease and other neurodegenerative diseases.

Clinical improvement in depressed patients treated with an selective serotonin reuptake inhibitor (SSRI) and methylfolate (0.5 mg q.d. to 1 mg q.d.), a form of folate that more readily crosses the blood-brain barrier, was 30% greater compared to matched patients treated with an SSRI only. A systematic review of controlled studies (total N = 247) concluded that folate augmentation (1 mg q.d. to 15 mg q.d.) enhanced the efficacy of conventional antidepressants.

Resource
1. Sadock BJ, Sadock VA, Ruiz P: Kaplan and Sadock's Comprehensive Textbook of Psychiatry. Ninth Edition. Lippincott Williams & Wilkins. Chapter 13.9.

Answered by: Dr. Hany Bissada

8. Treatment of *Coccidioides immitis*

What is the best treatment of *Coccidioides immitis*?

Submitted by: Anonymous

Coccidioides immitis is one of the endemic mycoses. It is most notable for causing “valley fever.” This condition is characterized by respiratory symptoms resulting from the inhalation of the spores of the fungus, *Coccidioides immitis*. The spectrum of illness ranges from uncomplicated acute pneumonias in otherwise immunologically intact individuals, to severe pneumonias in those who are immunocompromised. Other conditions include asymptomatic pulmonary nodules, asymptomatic pulmonary cavities, chronic progressive fibrocavitary pneumonia and disseminated disease. The decision to treat is based upon clinical manifestations. There is currently little data to support the treatment of an uncomplicated acute coccidioidal pneumonia in those who are immunologically intact as the condition is usually self-limited, resolving spontaneously. In persons who are immunocompromised such as those receiving cancer chemotherapy, or biologic modulators for rheumatologic disorders or those with infection with HIV, or who are pregnant, treatment may be warranted as they may be less able to effectively manage pulmonary coccidioidal infections. The treatment ranges from oral itraconazole (fluconazole in pregnancy), to IV amphotericin B. Specific treatment recommendations may be found in the Infectious Diseases Society of America Guidelines, entitled “Coccidiomycosis.”[1]

Reference

1. Galgiani JN, Ampel NM, Blair JE, et al: Coccidiomycosis. Clin Infect Dis 2005; 41(9):1217-23.

Answered by: Dr. John M. Embil

9. Recurrent Persistent Atrial Fibrillation

What is the latest treatment for recurrent persistent atrial fibrillation (AF)?

Submitted by: Anonymous

Rate control with a β-blocker (*e.g.*, atenolol 50 mg q.d.) or calcium channel blocker (e.g., diltiazem 240 mg q.d.) is the mainstay of therapy in patients with frequent persistent AF. Very symptomatic patients will require rhythm control with sotalol, propafenone or amiodarone. The decision regarding anticoagulation to prevent thromboembolic events depends on the presence of valvular disease, heart failure, diabetes, > 75-years-old, hypertension and prior stroke.

The latest treatment for frequent persistent AF is pulmonary vein isolation. This is a percutaneous procedure done through the femoral vein with transseptal catheterization and creation of multiple radio frequency burns around the pulmonary veins to prevent extrasystoles that arise from these areas from spreading to the rest of the left atrium. This procedure is performed throughout Canada by experienced electrophysiologists but often there is a very lengthy waiting list (more than one year in some cases). A CT scan or MRI is done beforehand to assess the anatomy of the left atrium and pulmonary veins. There is a risk of up to 5% of cardiac tamponade during the procedure. Pulmonary vein stenosis and atrial-esophageal fistula are rare but serious and potentially fatal complications.

One-third of patients will have AF in the first three months after the procedure because of atrial injury but this resolves with time. About 20% of patients will require a second procedure and about 70% have long-term (more than three years) benefit with freedom from AF.

The 2006 American College of Cardiology/American Heart Association/European Society of Cardiology guidelines for the management of AF consider pulmonary vein isolation as a reasonable alternative to pharmacological therapy to prevent recurrent AF in symptomatic patients, such as those with arrhythmia-related palpitation, fatigue, or effort intolerance, who have little or no left atrial enlargement and who have failed at least one antiarrhythmic drug. Elderly patients, who are in general at higher risk of developing complications and those with longstanding persistent AF, are less than optimal candidates.

The Canadian Cardiovascular Society is developing updated guidelines for the management of AF which will be released in 2010 and will include recommendations for pulmonary vein isolation.

Answered by: Dr. Bibiana Cujec

10. Significance of Findings of Chronic Deep Vein Thrombosis

What is the significance of findings of chronic deep vein thrombosis (DVT) reported on venous Doppler ultrasound?

Submitted by: Sumitha Parambil, MD, Chatham, Ontario

The issue of chronic clot on ultrasound usually arises in the case of patients with known previous DVT who present with new symptoms in the previously affected limb. It is difficult to distinguish between a recurrent DVT vs. post-thrombotic syndrome. Fifty per cent of patients who have had a previous DVT will be left with ultrasound findings of chronic DVT even after six to 12 months of anticoagulation therapy. Our standard practice is to obtain a repeat compression ultrasound of the affected limb after three to six months of anticoagulation therapy in order to set a new "baseline" image with which future ultrasounds can be compared to. If the patient presents with new symptoms, an ultrasound is performed. We consider the event to be a recurrent DVT if there is a new clot compared to the six month ultrasound and treat accordingly. If the ultrasound is relatively unchanged we consider this to be a case of post-thrombotic syndrome.

A patient with no known history of DVT and has symptoms of acute DVT with an ultrasound showing chronic clot is more difficult. Based on limited evidence, we would recommend repeating the ultrasound in one week. If there is progression, we treat this as an acute DVT and if the ultrasound remains unchanged we would usually advise against anticoagulation therapy. When there is uncertainty about the appropriate management in these difficult cases, we would recommend consultation with a thromboembolism specialist.

Resource

1. Tapson VF, Carroll BA, Davidson BL, et al: The Diagnostic Approach to Acute Venous Thromboembolism. Clinical Practice Guideline. American Thoracic Society. Am J Respir Crit Care Med 1999; 160(3):1043-66.

Answered by: Dr. Cyrus Hsia and Dr. Leonard Minuk

11. Hypertrophic Pulmonary Osteoarthropathy

What is the clinical significance of a diagnosis of hypertrophic pulmonary osteoarthropathy?

Submitted by: Madeline O'Connor, MD, Ottawa, Ontario

Hypertrophic pulmonary osteoarthropathy is a syndrome characterized by clubbing of the fingers and sometimes toes, as well as inflammation of the periosteum of long bones (periostitis), the latter manifesting as pain and sometimes edema. This is an important diagnosis to make, since a large percentage of non-hereditary forms of this syndrome are caused by lung cancer. This syndrome sometimes masquerades as arthritis; an assessment for possible lung cancer is hence part of a complete evaluation of arthritis for patients who present in this way. If the diagnosis is not recognized clinically and bone x-rays are ordered, changes of periosteal elevation should be a clue to the diagnosis.

Resource

1. Goldman L, Ausiello DA: Cecil Medicine, 23rd Edition. Saunders, 2007, pp.1-3120.

Answered by: Dr. Michael Starr and Dr. Emil Nashi

12. Treatment of Bell's Palsy

What is your treatment of Bell's palsy? Do you use antivirals and steroids?

Submitted by: Peter A. Loveless, MD, Hamilton, Ontario

The treatment of Bell's palsy involves pharmacological management, eye care and an appropriate follow-up assessment. Because the inflammation of facial nerve is considered to be the cause of Bell's palsy, corticosteroids are helpful in enhancing the resolution of symptoms of Bell's palsy by reducing the inflammation. There is significant improvement in outcome when prednisone is initiated within 72 hours of the onset of symptoms. Use of antiviral agents is controversial as some of the previous trials have shown limited benefit but recent randomized controlled trials showed no benefit. Because of the weakness of orbicularis oculi muscle, there is impairment of eye closure and abnormal tear flow which poses eye to risk of corneal dryness, ulceration and foreign body trauma. Thus, use of artificial tears, lubricants and an eye patch is very important.

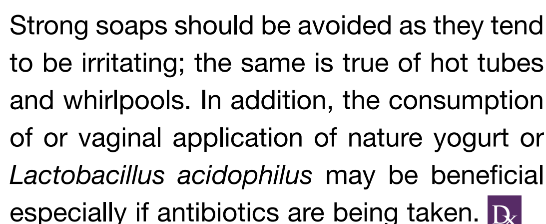
Answered by: Dr. Abdul Qayyum Rana

13. Preventing Relapse of Recurrent Vaginitis

Any tricks to prevent relapse in recurrent vaginitis?

Submitted by: Gilbert Blanchard, MD, Bas-Caraquet, New Brunswick

Factors that predispose to recurrent vaginitis are alkaline vaginal pH due to menstrual fluid, semen or a decrease in lactobacilli, as well as poor hygiene and frequent douching. In order to reduce the incidence of vaginitis, the vulvar area should be clean and dry with the avoidance of pantyhose and tight pants which tend to keep the vulva moist. Cotton underwear helps absorb moisture. Douching and deodorized tampons alter vaginal pH and can cause exacerbation of symptoms. Tampons should not be left in for long periods of time.



Strong soaps should be avoided as they tend to be irritating; the same is true of hot tubes and whirlpools. In addition, the consumption of or vaginal application of nature yogurt or *Lactobacillus acidophilus* may be beneficial especially if antibiotics are being taken. Dx

Resource

1. Anderson MR, Klink K, Cohrssen A: Evaluation of Vaginal Complaints. JAMA 2004; 291(11):1368.

Answered by: Dr. Victoria Davis