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Answers to your questions from medical experts

1. Would testosterone overcome the catabolic effects of prednisone in a male patient, 51, who has temporal arteritis and is on prednisone, 50 mg? His complete physical and biochemistry are normal, including his prostate specific antigen.

Submitted by:
Dr. Steve Coyle
General practitioner
Winnipeg, Manitoba

Testosterone is unlikely to overcome the catabolic effects of high-dose prednisone therapy in this clinical situation.

To minimize these adverse effects of steroids, one should aim to taper the prednisone dose as rapidly as possible. In patients with temporal arteritis, high-dose steroids are required initially to prevent permanent visual loss. However, most patients can be tapered to a daily prednisone dose of no more than 7.5 mg to 10 mg within four weeks of starting therapy. This will minimize the well-known negative effects of steroids on skin, muscle, and bone. As well, to prevent steroid-induced osteoporosis in patients such as this one initiating prednisone therapy (which is expected to last more than three months at doses greater than or equal to 7.5 mg a day), bone protecting co-therapies should be initiated together with prednisone. These co-therapies include elemental calcium, 1500 mg a day, vitamin D, 800 IU a day, and a bisphosphonate. Testosterone would be reserved for treatment of any associated symptoms of hypogonadism or andropause.

Answered by:
Dr. Philip A. Baer
Rheumatologist
Scarborough, Ontario

For girls using birth control pills, is it safe to use them continuously for years, or is it better to stop for a period of time?

Submitted by:
Dr. Hayam El-kateb
General practitioner
Settler, Alberta

It is safe to continue using the birth control pill until the patient wants to try to have a family.

Answered by:
Dr. Paul Claman
Reproductive endocrinologist/
fertility specialist
Ottawa, Ontario

Bisphosphonates have an indication for the prevention of osteoporosis. At what T-score would one initiate bisphosphonate prevention therapy, keeping in mind that raloxifene also has level A evidence for osteoporosis prevention?

Submitted by:
Dr. David S. Rosenberg
General practitioner
Scarborough, Ontario

Alendronate and risedronate are aminobisphosphonates. These potent agents inhibit the osteoclast and effectively decrease bone resorption. Alendronate is beneficial in the prevention of vertebral, hip, and other non-vertebral fractures in post-menopausal women. Risedronate has similarly been shown to be effective in preventing fractures and bone loss in early post-menopausal women. Both aminobisphosphonates are approved as first-line preventive therapy in post-menopausal women with low bone density.[1] The recommended dose of alendronate and risedronate is 5 mg daily. Once-weekly regimens have been shown to have similar effects.

Raloxifene is a selective estrogen receptor modulator. It can be considered for post-menopausal women who have bone density T-scores of less than –1 at the lumbar spine or hip. Additional advantages include its extraskeletal benefits. Reductions in total and low-density lipoprotein cholesterol, fibrinogen, lipoprotein A, and homocysteine levels have been seen with raloxifene use.[2] In the MORE trial, cardiac events were also reduced by 40% in women at increased risk of cardiovascular disease. An 84% reduction in estrogen receptor-positive breast cancer has been recorded. The incidence of thromboembolic events with raloxifene is comparable to hormone replacement therapy. A history of thromboembolic disease is a contraindication to therapy.

In post-menopausal women with a T-score of less than –1, but greater than –2.5, antiresorptive therapy with aminobisphosphonates or raloxifene can be considered. The benefits of aminobisphosphonate use are ease of administration with once-weekly dosing. Both alendronate and risedronate are very well-tolerated.

Raloxifene offers additional extraskeletal benefits. It is particularly beneficial for those at an increased risk of coronary artery disease, stroke, or breast cancer.

It is anticipated that maintaining bone density and preventing progressive bone loss following the onset of menopause will be associated with a significant reduction in the development of osteoporosis and fragility fracture. CME

References
1. Brown JP, Josse RG, Scientific Advisory Council of the Osteoporosis Society of Canada: 2002 Clinical practice guidelines for the diagnosis and management of osteoporosis in Canada. CMAJ 2002; 167(10 suppl):S1-3.
2. Khan A: Advances in osteoporosis therapy. 2003 update of practical guidelines. Can Fam Physician 2003; 49:441-7.

Answered by:
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