

Frequently Asked Questions

Our surveys show you want more questions and answers, so we introduced a new department called “Frequently Asked Questions” or “FAQs.” We welcome your feedback at cardio@sta.ca.

Cerebral Aneurysms

As presented at the University of Calgary’s **Stroke Prevention and Treatment in Primary Care CME Conference** by **John J. Kelly**, MD, neurosurgical resident; **Deon F. Louw**, MD, FRCSC; and **Garnette R. Sutherland**, MD, FRCSC.

1. What are the risk factors for aneurysm?

- Smoking
- Family history
- Female
- Polycystic kidney disease
- Collagen vascular disorders
- Hypertension
- Alcohol

2. What are the symptoms?

- Headache
- Nausea/vomiting
- Photophobia
- Neck stiffness
- Altered level of consciousness
- Focal neurologic deficit

3. What tests should be done?

If the clinical presentation suggests SAH, an immediate CT scan should be done. If the CT scan is negative, a lumbar puncture must be performed and CSF examined for xanthochromia. If symptoms of SAH are remote and CSF is unremarkable, clinical suspicion of SAH still warrants a neurosurgical consultation. It is imperative that a SAH diagnosis not be missed.

4. What are the treatment options?

- Microsurgery
- Endovascular intervention

Direct surgical repair is still the gold standard of treatment.

For an in-depth article on cerebral aneurysms please go to page 28.

Congestive Heart Failure

As presented at **The 17th Annual Cardiology Update for Family Physicians** at The Royal Alexandra Hospital by **Michael C. Y. Chan**, MD, FRCPC; and **Rosa Gutierrez**, MN, NP

1. Is an ARB equivalent to ACEI?

No. ACEI should always be tried first. ARB is indicated in those patients who are intolerant to ACEI, e.g., patients with a cough.

2. Should I use beta blockers in every heart failure patient?

Yes. Except for those patients who are Class IV, and have decompensated CHF, with severe fluid overload, severe renal insufficiency or symptomatic hypotension.

3. Is exercise safe for stable CHF patients?

Yes. A mild to moderate aerobic exercise program is safe, and may improve a patient's sense of well-being and outcome.

4. On whom should I order an echocardiogram?

Every patient suspected of having CHF should have an echocardiogram.

5. How do I prevent hospital admissions for CHF?

Patient and family education and support are very effective in preventing hospital admissions for heart failure.

For an in-depth article on CHF, please go to page 34.

ALLHAT: Is it all that?

By Henry Chung, MD; and
Brett Heilbron, MB, ChB, FRCPC, FACC

1. Which patients were eligible for the ALLHAT trial?

Eligible patients included were 55 or older, with hypertension, and at least one other CHD risk factor. Risk factors included:

- previous MI,
- left ventricular hypertrophy,
- stroke,
- history of Type 2 diabetes,
- current cigarette smoking,
- HDL < 0.91 mmol/L, and
- record of other atherosclerotic CVD.


Individuals with an ejection fraction < 35%, history of heart failure, or renal insufficiency were excluded.

2. Which drugs were tested in ALLHAT?

Patients were randomized to receive:

- chlorthalidone (12.5 mg/day to 25mg/day)
(15,244 patients from the study population)
- amlodipine (2.5 mg/day to 10 mg/day)
(9,048 patients from the study population)
- lisinopril (10 mg/day to 40 mg/day)
(9,054 patients from the study population)

3. What was the major result of the trial?

- The primary end point, as well as all-cause mortality, was similar for each of the three drugs.
- The results of the secondary cardiovascular end points generally revealed superiority of chlorthalidone.
- The rates of combined CVD, stroke, and heart failure were significantly higher in the lisinopril arm compared to the chlorthalidone arm.
- In the amlodipine arm, there was a higher rate of heart failure, but the other secondary outcomes were similar. 

For the review on ALLHAT, please go to page 45.