

You asked about...

Answers to your questions from medical experts

1. Should patients treated with fertility drugs be more closely supervised for ovarian/breast cancer?

Submitted by: **Dr. Danielle Fisch**, general practitioner, North Hatley, Quebec.

Irregular menses and fertility problems due to oligo-ovulation are due to polycystic ovarian syndrome (PCOS) in 80% of cases. Women with PCOS appear to be at higher risk for breast cancer and endometrial cancer. Delayed childbearing is associated with both an increased risk of breast and ovarian cancer. It is for these reasons that it has been difficult to sort out the specific cancer risks of fertility drugs.

Recent data from large populations of exposed women have now shown that fertility drugs do not appear to put women at a higher

risk of ovarian cancer. The risk of fertility drugs and breast cancer is as yet unknown.

Irrespective of the question about the risks of fertility drugs, infertility itself does put women at risk for ovarian cancer, and women with a history of irregular menses may be at increased risk for breast cancer.

Answered by: **Dr. Paul Claman**, professor, clinical director, IVF-ET program, division of reproductive medicine, department of obstetrics and gynecology, faculty of medicine, The Ottawa Hospital, University of Ottawa, Ottawa, Ontario.

2. Allopurinol should not be started during an acute attack of gout. When should it be started?

Submitted by: **Dr. B.L. Cheung**, general practitioner, Toronto, Ontario.

Allopurinol should not be started during an acute episode of gout because fluctuation of the serum uric acid level may prolong the acute inflammatory attack.

Attention should be directed to prevention and prophylaxis only once the acute episode has totally resolved.

There is no set time in the literature, only the notion of complete resolution of inflammation. A week after the painful swelling has gone would be adequate.

Prophylaxis of painful flares after the initiation of prevention is also possible. Colchicine 0.6 mg daily or twice daily is effective in diminishing the frequency or

severity of flares induced by initial allopurinol therapy. It may be discontinued after a six-month-free interval. Some physicians prefer to give the patient a supply of nonsteroidal anti-inflammatories (NSAIDs) with "how to" directions concerning the attacks, if needed. I prefer prophylaxis, especially in the elderly population.

Answered by: **Dr. Monique Camerlain**, Consultant member, services de rhumatologie, Centre Hospitalier Universitaire de Sherbrooke, Sherbrooke, Quebec.

3. Please comment on the prevalence and incidence rates, diagnostic criteria, treatment, management, and prognosis of hypoglycemia unawareness.

Submitted by: **Dr. Eric Rumack**, occupational physician, Toronto, Ontario.

Hypoglycemia unawareness is common in patients with Type 1 diabetes (25%). It is characterized by the loss of autonomic warning symptoms before the development of neuroglycopenia.¹

Results of the Diabetes Control and Complications Trial (DCCT) increased emphasis on intensive insulin treatment, but also drew attention to the accompanying hypoglycemia risk with such therapy.² The glucose threshold for symptoms of hypoglycemia is decreased so that an individual is unaware of an early warning of falling glucose levels. It is associated with a high risk for more severe hypoglycemic episodes that sometimes result in seizures and coma. While the cause is not entirely clear, the strongest predictors are a low HbA_{1c} and a prior history of frequent episodes of hypoglycemia.

Treatment options are limited. Fortunately, strict avoidance of hypoglycemia, for even a relatively brief period, can often improve the syndrome. Usually an increase in HbA_{1c} of 0.5% to 1% is the result, although the number of low glucose

levels, and not the HbA_{1c} per se, is probably the most important factor. Avoidance of hypoglycemia for a number of days results in both improved hormone responses to hypoglycemia and an enhanced response of the body to epinephrine. This improvement often lasts for some time and, if better control can be reinstated with fewer hypoglycemic episodes, hypoglycemia unawareness may not recur.

Health-care providers should consider updating their patients several years post-diagnosis with preventive strategies, such as insulin modifications (e.g., minor changes in dose or newer insulin analogs), or minor dietary changes (e.g., light snacks at high-risk times) while maintaining intensive insulin therapy.³

Patients should wear a MedicAlert® bracelet at all times. For patients who live alone, drive long distances, or work at jobs that carry a risk of injury, it is essential that the "perfect control" be achieved safely and slowly. Temporary cessation of handling vehicles and machinery is advisable for individual cases,

based on the severity of the condition. Lessening the individual daily burden of this condition without compromising long-term health may be possible.

Answered by: **Dr. Usman Chaudhry**, staff endocrinologist and internist, department of internal medicine, Moncton Hospital, and Dalhousie University affiliate, Moncton, New Brunswick.

References

1. Mokan M, Mitrakou A, Veneman T, et al: Hypoglycemia unawareness in IDDM. *Diabetes Care* 1994; 17(12):1397-1403.
2. The Diabetes Control and Complications Trial Research Group: The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 1999; 329(14):977-86.
3. Cryer PE, Davis SN, Shamoon H: Hypoglycemia in Diabetes. *Diabetes Care* 2003; 26(6):1902-12.



The graphic features a blue background with a green pill-shaped banner at the top containing the word "INTRODUCING" in white. Below this is a stylized white logo of a fan of dots. The word "Nexium" is written in large white letters, with a small "P" in a square to its left. Below "Nexium" is the word "esomeprazole" in smaller white letters.

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