Clinical Briefs in
Primary Care

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Evidence-based updates in primary care medicine

Online Supplement to *Clinical Cardiology Alert, Critical Care Alert, Hospital Medicine Alert, Infectious Disease Alert, Integrative Medicine Alert, Neurology Alert, OB/GYN Clinical Alert, Primary Care Reports*

Volume 22, Number 2 February 2017

Orthostatic Changes in BP Among Hypertensives

SOURCE: Townsend RR, Chang TI, Cohen DL, et al. Orthostatic changes in systolic blood pressure among SPRINT participants at baseline. *J Am Soc Hypertens* 2016;10:847-856.

Upon standing from a sitting (or supine) position, compensatory changes in heart rate and vascular tone maintain both systolic blood pressure and diastolic blood pressure fairly consistently. Postural changes in blood pressure of more than a 20 mmHg drop in systolic blood pressure or a 10 mmHg drop in diastolic blood pressure (or both) within three minutes of standing are defined as orthostatic hypotension, although only a minority of individuals with measurable orthostatic hypotension experience any clinical manifestations such as dizziness, lightheadedness, or falls. On the other hand, orthostatic hypotension has been associated with worsened cardiovascular outcomes, even when asymptomatic.

Townsend et al reported on baseline data from the SPRINT trial, which collected data on orthostatic blood pressure changes in 8,662 participants at baseline. Overall, 7% (n = 634) of enrollees demonstrated orthostatic hypotension, although the element by which they met the diagnostic criteria for orthostatic hypotension varied: 294 subjects met systolic blood pressure criteria, 227 met diastolic blood pressure criteria, and 113 met both.

No one has suggested that asymptomatic orthostatic hypotension requires treatment. On the other hand, symptomatic orthostatic hypotension places patients at risk for falls with subsequent consequences as hip fractures, leading to increased mortality.

Because patients may not always be forthcoming about symptoms referable to orthostatic hypotension, more routine measurement of orthostatic blood pressure changes in hypertensive patients may help identify those at risk. ■

Atopic Dermatitis Associated with Smoking

SOURCE: Kantor R, Kim A, Thyssen JP, Silverberg JI. Association of atopic dermatitis with smoking: A systematic review and meta-analysis. *J Am Acad Dermatol* 2016;75:1119-1125.

Atopic dermatitis is a chronic, often lifelong disorder affecting people of all ages. In addition to troublesome cosmetic effects, the pruritus of atopic dermatitis has been demonstrated to be extremely disruptive to sleep in children, and often requires systemic antihistamine treatment for control.

A lifelong requirement for periodic treatment with topical steroids and/or topical calcineurin inhibitors (e.g., pimecrolimus, tacrolimus) is not uncommon for mild-to-moderate sufferers. Severe atopic dermatitis may require systemic treatments, including immune modifiers such as cyclosporine.

Smoking has been demonstrated to be associated with atopic dermatitis. The association was found to be statistically significant in children and adults. Of particular concern, smoking in the home was associated with atopic dermatitis in passively exposed children.

There is some predictability within families with an atopic diathesis (i.e., common presence of atopic disorders such as asthma, allergic rhinitis, and eczema) that children are more likely to develop atopic dermatitis. In addition to the many other good reasons to stop smoking, we can add an increased incidence of atopic dermatitis. ■

An Action Plan for Eczema

SOURCE: Sauder MB, McEvoy A, Ramien ML. Prescribing success: Developing an integrated prescription and eczema action plan for atopic dermatitis. *J Am Acad Dermatol* 2016;75:1281-1283.

Many clinicians may be familiar with the concept of an action plan in reference to asthma management. National guidelines suggest that providing patients with a stratified plan to address intensification of their asthma treatment regimen based on symptoms and measurements of peak flow rates may enhance control.

Recently, similar advice has been offered — and supported by favorable outcomes from a randomized, controlled trial — for patients suffering from atopic dermatitis.

The proposed atopic dermatitis action plan features three 'zones' (green, yellow, and red), similar to asthma action plans. In the green zone, eczema is 'under control,' and patients should continue their daily moisturizer, possibly with use of their topical steroid and/or topical calcineurin inhibitor (e.g., tacrolimus,

pimecrolimus). The yellow zone indicates worsening eczema, which calls for increased dosing of steroids or calcineurins. The red zone indicates uncontrolled eczema, which indicates that clinician contact is appropriate and a prescription for stronger corticosteroids is needed. At this point, action plans for eczema are a fairly new concept. It is anticipated that such action plans will evolve as we learn more about their efficacy in enhancing patient self-care and timely consultations. ■

Prophylaxis of Genital Herpes Recurrences with Antivirals

SOURCE: Sands-Lincoln M, Goldmann DR. Antiviral drugs to prevent clinical recurrence in patients with genital herpes. *Am J Med* 2016;129:1264-1266.

For now, herpes has outsmarted us. Antivirals can reduce the duration of acute attacks, decrease the number of days of viral shedding, and reduce the frequency of recurrences, but they do not eradicate the latent virus or alter the the natural course of disease. Once antiviral treatment ends, the frequency and severity of attacks resumes unaltered.

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However, the good news is that the three currently approved antivirals (acyclovir, famciclovir, valacyclovir) can produce a major, albeit imperfect, effect on recurrences when administered daily as prophylaxis. The literature suggests recurrences can be reduced by as much as 70-80% in patients presenting with frequent recurrences.

Long-term data (one to six years) support the safety and efficacy of the antivirals, each of which has demonstrated similar benefit.

In the absence of head-to-head clinical trials, no substantial differences in efficacy or tolerability among the three potential treatments has been demonstrated.

Our experience with antivirals against influenza has taught us that problematic levels of resistance can occur quickly, but similar trends for genital herpes have not been observed. ■

Atrial Fibrillation Still a Mortal Disorder

SOURCE: Fauchier L, Villejoubert O, Clementy N, et al. Causes of death and influencing factors in patients with atrial fibrillation. *Am J Med* 2016;129:1278-1287.

The advent of warfarin for anticoagulation in patients presenting with atrial fibrillation (AF) provided dramatic risk reductions; more than 60% reduced risk of ischemic stroke, and more than 25% reduced mortality. The addition of novel anticoagulants (factor Xa and antithrombin agents) reduces risk even more.

It may come as a surprise that of the 5.5% annual risk of death noted in a population of AF patients, the three most common causes of death were heart failure (29%), infection (18%), and cancer (12%).

Of course, anticoagulation does not totally eliminate stroke-related deaths in AF, not only because not all strokes may be caused by other disorders besides AF, but also because utilization of anticoagulants, particularly warfarin, also is imperfect.

Stroke and bleeding remain less frequent, but nonetheless important, causes of death in the AF population studied (n = 7,668), each accountable for 7% of deaths.

Although we have much to celebrate in the efficacy of established and novel treatments for stroke prevention in AF, the authors proposed that we might pay greater attention to prevention, identification, and management of heart failure, as it is the most frequent cause of death in patients presenting with AF. ■

Identifying Risk for Macrovascular Events in Diabetes Patients

SOURCE: Mohammedi K, Woodward M, Zoungas S, et al. Absence of peripheral pulses and risk of major vascular outcomes in patients with type 2 diabetes. *Diabetes Care* 2016;39:2270-2277.

Cardiovascular disease is the most common cause of death for patients suffering from type 2 diabetes. Even though it is also common for type 2 diabetes patients to suffer from dyslipidemia and hypertension, the cardiovascular disease risk is disproportionate to these burdens. How might we better identify type 2 diabetes patients who are at particularly high risk?

Creators of the ADVANCE trial enrolled type 2 diabetes patients (n = 11,120) and compared tight vs. standard glucose control for cardiovascular disease outcomes. However, the authors were unable to confirm any macrovascular benefit of tight control.

At enrollment into ADVANCE, researchers sought and recorded peripheral pulses (dorsalis pedis and posterior tibial, bilaterally) on physical exam.

Over a median of five years of follow-up, absence of either pulse predicted increased risk for myocardial infarction, stroke, cardiovascular death, heart failure, and all-cause mortality.

The absence of either of the pulses had similar predictive value, and risk of adversity increased with the number of missing pulses.

Diabetic patients deserve our best efforts to prevent, forestall, or mitigate cardiovascular events. The simple clinical maneuver of peripheral pulse palpation can help us identify a subgroup of type 2 diabetes patients who are at measurably increased risk. ■