

Clinical Briefs in Primary Care

By Louis Kuritzky, MD

Evidence-based updates in primary care medicine

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Sexual Dysfunction Among Diabetics

SOURCE: Owiredu WKBA, Alidu H, Amidu N, et al. Sexual dysfunction among diabetics and its impact on the SQoL of their partners. *Int J Impot Research* 2017;29:250-257.

Among diabetic men, the pathophysiologic derangements leading to sexual dysfunction are evident. Neuropathy and vascular disease (microvascular and macrovascular) readily explain the disproportionate incidence of observed sexual dysfunction. Explanations for sexual dysfunction in diabetic women, some of whom also have exhibited a higher incidence of sexual dysfunction than age-matched, non-diabetic comparators, are more difficult to discern.

Of the topics related to sexual health, there is less research on the partner impact of sexual dysfunction. Encouragingly, interventions that restore erectile capacity in men (e.g., phosphodiesterase type 5 inhibitors, intracavernosal injection therapy, and vacuum constriction devices) have been associated with corresponding improvements in partner quality of life, albeit not without occasional partner reports of unwelcome improvements in erectile capacity, sometimes labeled “Viagravation.”

In a review of diabetic men (n = 130) and diabetic women (n = 116), evaluations of sexual quality of life in both genders was meaningfully affected by partner sexual dysfunction. Perhaps not surprisingly, age and duration of diabetes were the strongest predictors of sexual dysfunction

in diabetic men. The authors opined that insufficient attention has been given to the presence and effect of sexual dysfunction on the quality of life of patients and their partners. ■

When Gastrointestinal Complaints Are Not Prominent

SOURCE: Paez MA, Gramelspacher AM, Sinacore J, et al. Delay in diagnosis of celiac disease in patients without gastrointestinal complaints. *Am J Med* 2017;130:1318-1323.

Most clinicians think of celiac disease as primarily a gastrointestinal disorder. Hence, when patients present with typical symptoms (e.g., persistent non-acute abdominal pain, diarrhea) not explained by other disorders, identification of celiac disease by screening for anti-transglutaminase antibodies usually follows. But what about when the gastrointestinal symptom profile of celiac disease is not a prominent part of the picture? Manifestations of celiac disease can be as far reaching as anemia, osteoporosis, abnormal thyroid function tests, and abnormal liver function tests, none of which may produce an immediate prompt to consider celiac disease as the etiology.

Paez et al reviewed data on patients with biopsy-proven celiac disease (n = 101) treated at the Loyola University Medical Center. Patients who presented with gastrointestinal symptoms exhibited a median time to diagnosis of 2.3 months, compared to 42 months for those without gastrointestinal symptoms. While celiac disease certainly is not the most common

cause of anemia, osteoporosis, abnormal liver function tests, or abnormal thyroid function tests, these results suggest that clinicians should think of celiac disease earlier in the differential diagnosis process, since the aforementioned consequences are largely remediable through appropriate dietary restrictions. ■

Diuretic Use in Heart Failure

SOURCE: Ellison DH, Felker GM. Diuretic treatment in heart failure. *N Engl J Med* 2017;337:1964-1975.

Diuretics are employed in heart failure for symptom control, but they are not disease-modifying; that is, in contrast to angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, beta-blockers, aldosterone antagonists, hydralazine/isosorbide, and valsartan/sacubitril, each of which has demonstrated meaningful reductions in mortality in heart failure clinical trials, diuretics are employed solely for improved patient quality of life. Perhaps that helps explain why there is remarkably less clinical trial data specifically focused on diuretic therapies for heart failure.

Two areas in which knowledge about best diuretic use is particularly important are acute decompensated heart failure and the scenario of diuretic resistance. For patients with acute decompensated heart failure, a trial comparing twice-daily furosemide IV boluses vs. continuous infusion (using low-dose and high-dose regimens) did not demonstrate any statistically significant difference for the coprimary endpoint of the patient's global

assessment of symptoms. However, secondary endpoint outcomes, which must be regarded as hypothesis-generating rather than definitive since the primary outcome was not achieved, tended to favor high-dose regimens regarding dyspnea, weight change, and net fluid loss.

For diuretic resistance, the authors endorsed continuous diuretic infusion with stepwise dose increases to achieve a 3-5 liter/day urine volume until euolemia is achieved. The modest amount of clinical trial data to assist clinicians in choosing doses of diuretics, mode of administration, and target fluid losses suggests that much more information is needed. ■

The Ever-elusive Prescription for the Optimum Diet

SOURCE: Dehghan M, Mente A, Zhang X, et al. Associations of fats and carbohydrate intake with cardiovascular disease and mortality in 18 countries from five continents (PURE): A prospective cohort study. *Lancet* 2017;390:2050-2062.

Opinions about how to best structure optimum dietary constituents have gone through multiple dramatic changes

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Editor: Jonathan Springston

Executive Editor: Leslie Coplin

Physician Editor: Stephen Brunton, MD

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Customer Service: (800) 688-2421

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in the last three decades, with little consistency. Remember when eggs were bad because of cholesterol, and margarine was preferred to butter because of calories and fat, and fat, generally, was regarded as an anathema?

The Prospective Urban Rural Epidemiology study was an observational cohort (n = 135,335) of adults aged 35-70 years, followed for 7.4 years, representing 18 different countries, selected to represent the three tiers of low-, middle-, and high-income nations.

During the follow-up interval, 5,796 deaths and 4,784 nonfatal cardiovascular events occurred. Overall for carbohydrates, comparing the highest quintile of intake to the lowest (quintile 5 vs. quintile 1), the hazard ratio for mortality was 1.28. Perhaps surprisingly, carbohydrate levels were *not* associated with mortality from cardiovascular disease or with cardiovascular events. Additionally, somewhat contrary to the prevailing wisdom, intake of total fat was *inversely* associated with total mortality (hazard ratio, 0.77). Even the much-maligned saturated fat in the diet was associated with a reduced hazard ratio for total mortality (0.86). Each of these outcomes was statistically significant.

The authors' interpretation of their results, as quoted, is appropriate: "Global dietary guidelines should be reconsidered in light of these findings." ■

Dealing With Severe Acute Pain in the ED

SOURCE: Chang AK, Bijur PE, Esses D, et al. Effect of a single dose of oral opioid and nonopioid analgesics on acute extremity pain in the emergency department: A randomized clinical trial. *JAMA* 2017;318:1661-1667.

The desire to provide meaningful pain relief for patients with acute severe pain is complicated by concerns about potential overuse of opioids, sometimes leading to misuse, diversion, dependency, and addiction. Despite the commonplace nature of acute pain syndromes (e.g., acute fracture), the literature base comparing different analgesic strategies is modest.

Chang et al performed a randomized, controlled trial among adults (n = 411) presenting with severe acute pain to EDs

in the Bronx. The authors compared four different pain regimens, with the specific outcome of change in pain at two hours post-analgesic as measured on a 10-point (0-10) numeric pain rating scale. At baseline, the mean pain scale score was 8.7, indicative of moderately severe to severe pain.

The four regimens (each given as a single dose) were ibuprofen 400 mg/acetaminophen 1,000 mg, oxycodone 325 mg/acetaminophen 325 mg, hydrocodone 5 mg/acetaminophen 300 mg, and codeine 30 mg/acetaminophen 300 mg. At two hours, there was no statistically significant difference in pain reduction between the four different treatment arms. The success of a non-opioid treatment arm in direct comparison with three opioid treatment arms should justify greater consideration of non-opioid treatment for acute severe pain. ■

Reducing Falls Among Older Adults

SOURCE: Tricco AC, Thomas SM, Veroniki AA, et al. Comparisons of interventions for preventing falls in older adults: A systematic review and meta-analysis. *JAMA* 2017;318:1687-1699.

Most clinicians recognize the serious burden resulting from falls in senior citizens. Even when falls do not result in serious injury, fear of falls may be quite compromising. Seniors may be reluctant to report postural instability to their families, caregivers, or clinicians, lest their disclosure result in loss of autonomy, nursing home placement, or other restrictions.

Fortunately, as reported in this systematic review, a substantial number of randomized, controlled trials (n = 283 trials, which included 159,910 participants) provide convincing evidence that interventions are remarkably beneficial. Exercise, correction of impaired vision, supplemental calcium/vitamin D, and environmental interventions reduce falls. The interventions that were multimodal appear to produce additive benefits.

Although these results are encouraging, it is noted that there is some signal for an increase in falls when patients become more mobile subsequent to strength and exercise training. Clinicians are advised to caution patients to be cognizant of the risks of greater levels of activity while enjoying greater mobility. ■