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Clinical Briefs in
Primary Care®

The essential monthly primary care update

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Weight Loss Intervention on Antihypertensive Medication

Source: Jones DW, et al. *Am J Hypertens* 1999;12:1175-1180.

The hot study was a prospective randomized trial in hypertensive patients to determine if achieving diastolic blood pressures of 90, 85, or 80 were differentially associated with outcomes. One subgroup in this study population (n = 112) was selected on the basis of BMI more than 27 and were randomized to weight loss intervention, or control, in addition to the same stepwise antihypertensive therapy that all subjects received. Weight reduction intervention consisted of counseling by a registered dietitian, advice about food selection, and a diet of restricted calories with decreased fat intake. There were periodic contacts at least every 3-6 months throughout the study. Those in the control group were told that weight loss should be achieved, but received no further input in that regard.

At the six-month point, the intervention group had lost more weight than the control (approximately 1.4 kg), but at the 30-month point, no difference was seen.

The mean number of medications needed to achieve goal diastolic blood pressure was lower at the six-month point (2.9 vs 3.5 medications) for the intervention group than the control group; furthermore, this difference in medication requirement remained significantly lower for the duration of the 30-month trial, despite the regained weight in the intervention group, and despite the fact that at the end of the trial, there was no significant difference in weight loss between the groups. Jones and colleagues are unable to explain the persistent beneficial effect on blood pressure by an initial weight loss, but encourage renewed enthusiasm for early weight loss as a tool to potentially reduce the number of medications needed for blood pressure control, thus enhancing compliance and reducing expense. ■

Urgent Colonoscopy

Source: Jensen DM, et al. *N Engl J Med* 2000;342:78-82.

Although there have been case reports of successful evaluation and acute treatment of diverticular bleeding by urgent colonoscopy, there have been no studies to evaluate issues such as the complication or recurrent bleeding rate using this intervention. Urgent colonoscopy was defined as being performed 6-12 hours after hospitalization and within one hour of colonic sulfate purging (i.e., Golytely, Colyte). This report details experience from two separate studies.

In the first study (1986-1992), 17 of 73 diverticulosis patients with severe bleeding had diverticular hemorrhage as the etiology. In the second study (1994-1998), 10 of 48 patients had definite diverticular hemorrhage as the cause, 14 had presumptive diverticular hemorrhage, and 24 had incidental diverticulosis.

In the second study, all patients with definite diverticular hemorrhage received colonoscopic treatment consisting of local epinephrine injection or local tamponade for actively bleeding vessels, and bipolar coagulation for nonbleeding visible vessels.

In the group treated medically without colonoscopic treatment (e.g., transfusions), bleeding, requiring hemicolectomy, did occur in six patients, of whom two sustained surgical complications. Endoscopic treatment did not result in any complications or recurrent bleeds, and none of the endoscopically treated patients required surgical intervention. Even during the long-term follow-up (18-49 months), only one patient—a patient with presumptive diverticular hemorrhage on warfarin—rebled. Based upon these data, Jensen and colleagues suggest using surgical intervention only for those patients with definite or presumptive diverticular hemorrhage in whom medical or colonoscopic treatment has failed or produced complications. ■

Instability of Atherosclerotic Plaques

Source: Rothwell PM, et al. *Lancet* 2000;355:19-24.

The major complications of atherosclerosis are apparently related to stability of atheromatous plaques, not just extent of atherosclerosis. Unstable angina, MI, stroke, and transient ischemic attack (TIA) have all been associated with irregular or ruptured plaques. Although local factors like sheer stress and plaque structure are felt to be important, systemic factors like autoimmunity and infection, resulting in plaque inflammation and hemorrhage, also appear to play a role.

One important issue evaluated in this study was the relationship between plaque-surface irregularity and MI in subjects of the European Carotid Surgery Trial (n = 3007) for persons with symptomatic carotid stenosis. Evaluations included comparisons of carotid angiograms (bilateral) and carotid pathology specimens for the subgroup that underwent carotid endarterectomy (n = 1671). There is no information in this trial about markers of infection or inflammation, such as CRP.

The risk of nonstroke vascular death (i.e., essentially coronary artery disease death) was significantly higher in persons with plaque surface irregularity (RR = 1.67). Additionally, persons with surface irregularity in one carotid were more likely to have the same in the contralateral artery. Jensen and colleagues comment that traditional risk factors (HTN, cholesterol, smoking, diabetes) do not account for which persons will develop the demonstrably higher risk irregular plaques. ■

Vitamin E Supplementation and Cardiovascular Events in High-Risk Patients

Source: Yusuf S, et al. *N Engl J Med* 2000;342:154-160.

Observational studies indicate that persons who consume foods rich in vitamin E have a lower risk of coronary heart disease. Though such studies are useful for hypothesis generation, only randomized, controlled, interventional trials can provide the answer to whether at-risk persons can consume increased dietary or supplemental vitamin E and achieve a reduced risk of coronary end points. The Heart Outcomes Prevention Evaluation (HOPE) study is a double-blind randomized trial incorporating 400 IU of vitamin E daily over five years time in a group of patients considered high risk for cardiovascular events (n = 9541).

The primary end point was death from myocardial infarction (MI), stroke, and all cardiovascular causes combined. Secondary end points included death from any cause, and other cardiovascular end points such as hospitalization for congestive heart failure (CHF).

There was no significant difference in death from cardiovascular causes, MI, coronary heart disease, or strokes. Overall mortality did not differ in the treated group from the untreated group. Similarly, secondary cardiovascular and combined outcomes demonstrated no favorable (or deleterious) effects from supplementation with vitamin E.

Yusuf and associates conclude that data from this large prospective trial among individuals with increased risk for cardiovascular end points show no benefit over five years for administration of supplemental vitamin E. ■

Long-Term Outcomes of Persons with Lyme Disease

Source: Seltzer EG, et al. *JAMA* 2000;283:609-616.

A variety of anecdotal reports suggest that Lyme disease may be associated with long-term sequelae of diverse nature. Connecticut, which requires all Lyme disease to be reported, was the setting for the evaluation of 672 persons identified as having Lyme disease, compared with a matched group of persons without the disease. Follow-up was up to 11 years in duration (mean 51 months), and mean patient age was 36.

Most people (71%) identified no long-term sequelae, 9% felt they were still not cured, and 20% were uncertain if they were cured. Persons who felt they were not cured were more likely to suffer impairments in activities of daily living in years following treated Lyme disease. However, the data comparing the control cohort to the post-Lyme disease group indicated that there were similar frequencies of complaints among controls as among Lyme disease subjects. Additionally, persons who met the most stringent criteria for confirmed Lyme disease actually had a lower frequency of difficulties with daily activities than those whose fulfillment of diagnostic criteria was less complete, a percentage of whom must surely have been incorrectly diagnosed as having Lyme disease.

There were rare instances of Lyme disease sufferers who experienced significant complications such as (recurrent) arthritis in persons who did not receive prompt treatment and are genetically disposed to autoimmune-mediated arthritis. On the other hand, these data support clinicians who chose to advise their Lyme disease patients that adverse post-disease outcomes are the clear exception. ■

Development and Evaluation of an Abridged IIEF-5 as a Diagnostic Tool for Erectile Dysfunction

Source: Rosen RC, et al. *Int J Impot Res* 1999;11:319-326.

Erectile dysfunction has received considerable increases in attention by primary care clinicians as awareness of its prevalence, quality of life consequences, and ultimate treatability become more widespread. The International Index of Erectile Function (IIEF) has been validated as being highly sensitive and specific for measuring treatment efficacy in erectile dysfunction. This tool is not designed for diagnostic use and is a bit unwieldy for office screening. To meet the need of a more simple office screening device, Rosen and colleagues developed an abbreviated questionnaire that was used in multicenter trials investigating sildenafil (Viagra) for erectile dysfunction. The sample of men (n = 1047) who were evaluated completed both the original and the abridged IIEF. A group of 115 men without erectile dysfunction served as controls. The five questions asked for responses on a five-point scale about: 1) confidence in getting and keeping an erection; 2) sufficiency of turgidity for penetrations; 3) adequacy for maintaining an erection after penetration; 4) difficulty in maintaining an erection during intercourse; and 5) overall level of satisfaction with intercourse.

The abridged IIEF was found to be a sensitive and specific diagnostic indicator of erectile dysfunction. ■

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