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Clinical Briefs in
Primary Care
The essential monthly primary care update

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Supplement to *Clinical Cardiology Alert, Clinical Oncology Alert, Critical Care Alert, Infectious Disease Alert, Neurology Alert, OB/GYN Clinical Alert, Physician's Therapeutics & Drug Alert, Primary Care Reports, Radiology Alert,* and *Sports Medicine Reports.*

Volume 5, Number 6 **Pages 11-12** **May 2000**

Testosterone Supplementation in the Aging Male

Source: Kim YC. *Int J Impot Res* 1999;11:343-352.

The role of testosterone in achieving and maintaining erections in sexual settings (as opposed to "central" erections occurring spontaneously in a cyclic fashion throughout the day and night) remains uncertain. Men who are deficient in testosterone may suffer erectile dysfunction (ED), which may respond to testosterone supplementation, but the frequency of testosterone deficiency as a cause of ED in aging men is extremely low, typically less than 5%.

Much of the population of senior men who demonstrate low testosterone levels suffer from other significant health problems, and it is unclear whether these additional disorders are precipitants for the decline in testosterone levels. Since testosterone supplementation is not without consequence (economic costs, exacerbation of benign prostatic hyperplasia [BPH], induction or exacerbation of prostate cancer, worsened lipid profile risk patterns), it is important to ascertain the (potential) value of such supplementation.

Overt hypogonadism is found in only about 4% of men older than age 40-70, if defined as both low testosterone and high gonadotropins. If levels of bioavailable testosterone are the measurement designated to define clinically relevant hypogonadism, as many as 35% of men older than age 60 will be hypogonadal and may benefit from testosterone supplementation.

Kim suggests that in clinical settings where symptoms suggest hypogonadism, testosterone supplementation may be considered; dosages should provide a serum testosterone level of at least 240 ng/dL. There is an important need for a large, long-term trial to ascertain the risk-benefit relationship of testosterone supplementation in the elderly. ■

Task Force V: White-Coat Hypertension

Source: Pickering TG, et al. *Blood Press Monit* 1999;4:333-341.

It is not uncommon for some patients to manifest an elevation of blood pressure only in a medical setting, a circumstance variously designated as white-coat hypertension (WCH), isolated office hypertension, clinic hypertension, and other names. The most common definition is the presence of consistently elevated blood pressure measured in the office, in the company of consistently normal blood pressure measured in nonmedical settings. Similarly, the term "white coat effect" has been coined to indicate the difference between measured ambulatory blood pressure.

WCH is present in about 20% of individuals designated as having hypertension. The magnitude of the white-coat effect appears to increase with increasing age, and disproportionately involves systolic blood pressure; that is, the lower blood pressure found at home is primarily a difference in systolic measurements, while diastolic pressure shows substantially less variation.

Whether target organ damage results from WCH is a matter of debate, but the predominance of information suggests few measurable consequences in such important realms as left ventricular hypertrophy. On the other hand, WCH is associated with microalbuminuria, albeit to a lesser degree than sustained hypertension.

Overall morbidity and mortality for WCH is small on an absolute basis, being minimally to only modestly increased compared to normals, and never approaching the magnitude of frankly hypertensive patients.

A final consensus on the consequences of WCH remains to be achieved. Since a substantial minority of WCH patients go on to have sustained hypertension in a fairly brief time period (11-37% over 3-5 years), patients with WCH are recommended to undergo follow-up on an indefinite basis. ■

Results of Outpatient Multidisciplinary Pulmonary Rehabilitation

Source: Griffiths TL, et al. *Lancet* 2000;355:362-368.

The benefit of pulmonary rehabilitation for COPD has been demonstrated in meta-analysis to be beneficial over the short term (i.e., < 6 months). This trial, on the other hand, investigated long-term effects of pulmonary rehabilitation on use of health services, talking, and overall health status.

To be included in the study, patients must demonstrate an FEV_1 less than 60% predicted, with less than 20% reversibility after bronchodilator (beta-agonist), in stable condition for at least two months. Rehabilitation included occupational therapy, physiotherapy, diet counseling, and assistance with smoking cessation. Visits were arranged three times week-

ly for six weeks. Measurement of walking was done by the 10-meter shuttle-walk test; overall health status was measured by the SF-36.

Though not a primary end point of the study, relative risk of death in the treatment group was 0.5 when compared to the control (usual care) group. Pulmonary functions were equal in both groups. Although equal numbers of persons were admitted to the hospital from both groups, the actual number of admissions and number of days spent in the hospital were significantly less for the treated group. Walking, breathlessness, and overall health-status outcomes were more favorable in the treatment group. Griffiths and colleagues conclude that pulmonary rehabilitation should be incorporated into the traditional algorithm for long-term COPD management. ■

Efficacy and Safety of the Oral Neuraminidase Inhibitor Oseltamivir in Treating Acute Influenza

Source: Treanor JJ, et al. *JAMA* 2000;283:1016-1024.

Agents that have been shown to be efficacious only against type A viruses have limited treatment of influenza. The recent introduction of neuraminidase inhibitors, which are effective against influenza A and influenza B viruses, offer new breadth of antiviral activity. This study evaluated a large population (n = 629) of nonimmunized adults who were subject to spontaneous acute febrile respiratory illness. Inclusion criteria included no influenza vaccination for at least 12 months, overall good health, symptoms present for less than 36 hours, and temperature of at least 38°.

Treatment consisted of oseltamivir (Tamiflu) 75 mg or 150 mg orally twice daily vs. placebo. Participants were allowed to use acetaminophen for symptomatic relief, and their use of acetaminophen was quantified.

Overall duration of illness was reduced by more than 30% with oseltamivir treatment. Similarly, symptom scores were significantly improved with active treatment so that median severity of illness decreased by approximately 40%. Improvements in symptoms were notable as early as 24 hours after administration of the first dose. Fever was significantly reduced within 24 hours also, and persons who received oseltamivir used approximately 20% less acetaminophen for symptom relief. There were no serious clinical or laboratory side effects seen, and the withdrawal rate was the same as or less than placebo. Oseltamivir is effective and well tolerated in treatment of acute influenza A or B. ■

Self-Reported Arthritis-Related Disruptions in Sleep and Daily Life

Source: Jordan JM, et al. *Arch Fam Med* 2000;9:143-149.

Despite evolution in arthritis management tools, arthritis remains the most common cause of disability in persons older than age 65. Using the population of subjects participating in the National Follow-up Survey of Self-Care and Aging (n = 3485), Jordan and colleagues selected 1925 individuals for evaluation in this trial. The purpose of the study was to examine the effects of arthritis on use of self-care, complementary therapies, and traditional medical care.

More than half of these persons reported that arthritis had limited their activities in the previous year, including sleep and leisure activity disruption in approximately one-third.

Typical management strategies included over-the-counter remedies (topical and systemic agents), physician consultation, local physical therapies (e.g., heat, cold, massage), rest, and prayer, each of which was used by at least 40% of the arthritis sufferers. Persons with sleep disruption due to arthritis were much more likely to seek physician consultation (odds ratio = 3.66) than those without.

The importance of disrupted sleep as a consequence of arthritis may have been underestimated. Not only is the sleep disruption of immediate consequence, it increases the likelihood of use of a variety of other self-care and health professional resources. Clinicians are encouraged to increase their attention to sleep disruption as a consequence of arthritis. ■

Estrogen Replacement Therapy for the Treatment of Mild to Moderate Alzheimer's Disease

Source: Mulnard RA, et al. *JAMA* 2000;283:1007-1015.

Since women live longer than men, and Alzheimer's disease (AD) risk increases with advanced age, the problem occurs with twice the frequency in women. Whether estrogen replacement therapy (ERT) has an effect on AD has been an issue of some debate, and though initial impressions have been positive, the literature has not been definitive. Mulnard and colleagues selected 120 women with mild to moderate AD who had also recently undergone hysterectomy, thus eliminating concern for induction of endometrial hyperplasia by ERT. These women received either 0.625 mg or 1.25 mg estrogen daily for 12 months, or placebo.

Several tools were used for measuring outcome, including the Clinical Global Impression of Change scale (CGIC), the Clinical Dementia Rating Scale (CDR), the Ham Depression Scale, and the Multiple Effect Adjective Checklist. Multiple measurement tools for memory were also included.

There were no measurable persistent effects of ERT on any of the measured parameters, though there was a transient Mini Mental Status Examination improvement. Mulnard et al conclude that ERT therapy does not prevent progression of or improve the status of AD, and comment that the adoption of ERT for AD prior to randomized trials demonstrating its benefit is reason for concern. ■

Clinical Briefs in Primary Care? is published monthly by American Health Consultants. **Vice President/Group Publisher:** Donald R. Johnston. **Executive Editor:** Glen Harris. **Editor:** Stephen Brunton, MD. **Associate Managing Editor:** Robin Mason. **Copy Editors:** Neill Larmore, Michelle Moran, Rob Kimball.

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