AMERICAN HEALTH CONSULTANTS®

Clinical Briefs in Primary Care™

The essential monthly primary care update

By Louis Kuritzky, MD

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,* and *Sports Medicine Reports.*

VOLUME 7, NUMBER 6 PAGES 11-12 MAY 2002

Alcohol Consumption and Risk of Dementia

Source: Ruitenberg A, et al. *Lancet*. 2002;359:281-286.

Observational studies indicate salutary effects of moderate alcohol consumption (MAC) upon incidence of stroke and myocardial infarction. Since some portion of dementia is attributable to cerebral vascular ischemic changes, the idea that MAC might favorably affect cognitive impairment or dementia appears plausible. To study this relationship, Ruitenberg et al performed a prospective observational analysis examining participants in the Rotterdam study, a group of almost 8000 adults in The Netherlands, age 55 or older. At baseline (enrollment 1990-1993), all subjects were ostensibly free of dementia. The study was completed in 1999.

Over a mean follow-up of 6 years, 197 persons developed dementia, of which Alzheimer's disease was most frequent (74%), but vascular dementia was the next most common (15%).

Alcohol consumption was associated with a reduced risk of dementia. Persons who engaged in MAC had an 18-42% reduced likelihood of dementia when compared with heavy drinkers. Additionally, MAC persons had lower risk than non-drinkers. Both dementia (all forms combined) and vascular dementia alone showed comparable risk reduction patterns. No form of alcohol (beer, wine, liquor) showed a preferential effect. The fact that vascular dementia was reduced to a greater degree than Alzheimer's is consonant with recognized impact of MAC upon such cardiovascular risk factors as platelet aggregation and lipids. ■

Benefit of Atrial Pacing in Sleep Apnea Syndrome

Source: Garrigue S, et al. *N Engl J Med*. 2002;346:404-412.

Sleep apnea syndrome (SAS) has a diversity of immediate and distant consequences, including disrupted sleep, daytime fatigue resulting in traffic accidents, hypertension, increased cardiovascular morbidity, and increased mortality. Numerous therapies, none of which is wholly satisfactory for all patients, are available, including CPAP, theophylline, and surgical intervention. The serendipitous observation that persons who had received an atrial overdrive pacemaker noted improvement in SAS, combined with the knowledge that SAS is associated with both bradycardia and paroxysmal tacyharrhythmias, which might be favorably altered by atrial pacing, led to this current study.

Out of a population of 152 patients with dual-chamber pacemakers inserted at least one year previously, Garrigue and colleagues studied 15 patients with SAS confirmed by overnight sleep lab polysomnography. Subjects were assigned to be studied with and without overdrive pacing, set to provide a rate 15 beats per minute faster than the previously ascertained mean nocturnal heart rate in these individuals.

Overdrive atrial pacing produced a significant reduction in apnea, including a greater than 50% reduction in 13 of the 15 patients. Garrigue et al conclude that atrial overdrive pacing can effectively improve SAS in persons with pacemakers. Whether such an intervention might benefit other groups of patients, including those with no otherwise apparent indication for use of a pacemaker, remains an unanswered question. ■

Metabolic Syndrome Among US Adults

Source: Ford ES, et al. JAMA. 2002; 287:356-359.

The metabolic syndrome is defined as the presence of 3 or more of 5 potential measurements : 1) abdominal obesity (waist circumference > 102 in men, > 88 cm in women); 2) hypertriglyceridemia (>150 mg/dL); 3) low HDL < 40 in men, < 50 in women); 4) BP > 130/85; and 6) fasting glucose > 110 mg/dL. Metabolic syndrome has been recognized to be associated with increased cardiovascular risk, as well as increased risk of developing diabetes and increased total mortality. The most recent guidelines on lipid management by the National Cholesterol Education Program have affirmed a new prioritization for clinicians to address the metabolic syndrome, but the current prevalence of this syndrome in America has not been heretofore determined.

The National Health and Nutrition Examination Survey (NHANES) has been operative since the 1960s, and does periodic epidemiologic reporting on an ethically diverse adult population of men and women. Information to ascertain the prevalence of metabolic syndrome is available from this 1988-1994 data set (n = 8814).

Overall, more than 1 out of 5 Americans fits the criteria for the metabolic syndrome. The frequency of metabolic syndrome increases with age, so that in persons 60-69

years old, more than 40% had metabolic syndrome. Mexican-Americans had the highest overall frequency of metabolic syndrome. ■

Trial' Prescriptions to Reduce Drug Wastage

Source: Paterson JM, Anderson GM. *Am J Manag Care*. 2002;8:151-158.

DESPITE THE FACT THAT PRESCRIBED medications are often not used by patients, current statutes in most clinical settings do not allow patients to return unused medications for reissue to other patients. Hence, if a patient tries a medication, and is dissatisfied with it, does not tolerate it, no longer needs it, or is directed by a health professional to discontinue it for any reason, remainder medication is generally wasted.

Canada has tested a concept of allowing pharmacists to initially fill prescriptions for intended long-term medication with a "trial" amount first—allowing the patient to administer a small quantity of the medication, for instance 7-14 days supply—followed by the "full" balance of the prescription if both the patient and clinician were satisfied with the initial applicability of the prescription.

The overwhelming majority of patients (n = 249) who were offered "trial" prescriptions (86%) were content to receive that instead of a "full" prescription initially. More than half of the minority of patients who did not elect to receive a trial prescription reported sensible obstacles like the fact that they were leaving town, or that geographic limitations precluded ready return for a "full" prescription. Between 14-52% of "trial" prescriptions were ultimately discontinued. Overall, using trial prescriptions saved Canada $5.50 per trial prescription issued. American clinicians might similarly save important financial resources in some settings by the consideration of prescriptions of "trial" duration. ■

Cognitive Functioning of Long-Term Heavy Cannabis Users Seeking Treatment

Source: Solowij N, et al. *JAMA*. 2002;287:1123-1131.

WHETHER LONG-TERM HEAVY cannabis (LHC) use is associated with persistent impairment of cognitive function (COG) is an important public health issue not only because of the ponderous number of chronic marijuana users, but also because of potential employment by the medical profession as a therapeutic tool.

This study looked at a population of LHC users who sought treatment because of cannabis dependence. Participants must have not used cannabis for at least 12 hours. Data obtained through neurophysiologic testing were compared with a control population of age-matched nonuser controls. Most LHC users used cannabis essentially every day, approximately 2 joints daily.

LHC users had poorer word recall, poorer performance on increasingly complex executive function tasks, and a trend toward attentional dysfunction, in addition to deficits in other monitored functions. The LHC most prominently affected learning, retention, and retrieval as measured by the Rey Auditory Verbal Learning Test.

Despite deficits detected with these measurement tools, the results do not indicate a severe COG problem, and may require as long as 10-20 years of consistent LHC to occur. That the study is retrospective, and the population highly selected, may limit the generalizability of the findings. Additionally, whether sustained abstinence from LHC would ameliorate the detected dysfunctions is unknown. ■

A Randomized, Placebo-Controlled, Double-Blind, Flexible-Dose Study of Fluoxetine in the Treatment of Women with Fibromyalgia

Source: Arnold LM, et al. *Am J Med.* 2002;112:191-197.

BEST MANAGEMENT OF FIBROMYALGIA (FMG) remains a difficult challenge for most clinicians. Although meta-analyses suggest that tricyclic antidepressants are moderately effective, trials using selective serotonin reuptake inhibitors (SSRIs) have provided conflicting results. Since some positive results have been found with various SSRIs, a prospective placebo controlled trial of fluoxetine was felt to be of merit.

Study subjects (n = 60) were adult women with FMG, who received placebo or fluoxetine (FXT) once daily, titrated in 10-20 mg increments every 2 weeks to a maximum dose of 80 mg/d. Outcomes were assessed using the Fibromyalgia Impact Questionnaire and the McGill Pain Questionnaire.

Both the Impact and Pain Questionnaires showed statistically significant improvements in patients receiving fluoxetine. More than twice as many FXT recipients than placebo recipients experienced at least a 25% improvement in Fibromyalgia Impact Questionnaire score.

FXT was generally well tolerated. Perhaps the more favorable effects seen in this trial may be attributed to the higher doses of FXT used—earlier controlled trials used only 20 mg/d. Based on these results, clinicians may wish to consider flexibly dosed FXT for symptomatic management of female patients with FMG. ■

Clinical Briefs in Primary Care™ is published monthly by American Health Consultants. Copyright © 2002 American Health Consultants. **Vice President/Group Publisher:** Donald R. Johnston. **Editorial Group Head:** Glen Harris. **Editor:** Stephen Brunton, MD. **Managing Editor:** Robin Mason. **Associate Managing Editor:** Neill Larmore. **Senior Copy Editor:** Rob Kimball. This is an educational publication designed to present scientific information and opinion to health professionals, stimulate thought, and further investigation. It does not provide advice regarding medical diagnosis or treatment for any individual case. It is not intended for the layman.

Subscriber Information
Customer Service: 1-800-688-2421
E-Mail Address: neill.larmore@ahcpub.com
World Wide Web: http://www.ahcpub.com
Address Correspondence to: American Health Consultants 3525 Piedmont Road, Building Six, Suite 400 Atlanta, GA 30305.

THOMSON
AMERICAN HEALTH CONSULTANTS