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The essential monthly primary care update

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Antihypertensive Treatment and Measurement at Home or in the Physician's Office

Source: Staeesen JA, et al. *JAMA*. 2004;291:955-964.

A NOT-INSUBSTANTIAL MINORITY OF persons carrying a diagnosis of hypertension (HTN) actually have stress-induced transient episodes of HTN in clinicians' offices, which we call "white coat hypertension" (w-HTN). Because w-HTN does not appear to translate into increased risk for cardiovascular events, it is generally agreed that when persons are suspected of w-HTN, ambulatory monitoring of blood pressure (the gold standard) should be performed. Persons with normal ambulatory blood pressure (ABP), despite office BP elevations, do not require treatment, unless there is evidence of target organ damage.

Because ambulatory blood pressure monitoring (ABPM) is moderately expensive (approximately $100 in our community of Gainesville, Fla) and requires specialized equipment, it would be desirable if some simpler method of BP acquisition, such as home monitoring of blood pressure (HBPM) would suffice.

This blinded, randomized, controlled trial followed patients (n = 400) from 56 primary care practices, who were followed by traditional office monitoring, ABPM, or HBPM.

Patients who used HBPM ended up with less intensive medication regimens, but this was at the expense of less overall long-term BP control. On the other hand, HBPM (compared with office measurement) resulted in almost twice as many persons discontinuing BP medication entirely due to restoration of normotension; ie, consistent HBPM ultimately determined that they were normotensive off medication. HBPM is complementary to office measurement, and may help discover w-HTN. Because there is no large data-set upon which to base the normal range of home BP, the authors suggest outcome studies to establish such BP boundaries. ■

Inactivated Intranasal Influenza Vaccine and the Risk of Bell's Palsy

Source: Mutsch M, et al. *N Eng J Med*. 2004;350:896-903.

LATE IN 2000, THE SWISS DRUG Monitoring Center and others noted numerous reports of Bell's palsy in persons who had received NFLU. To better study the relationship between NFLU and Bell's palsy, a case-control study of 773 persons with Bell's palsy, compared with 2319 age-matched controls was performed.

More than 27% of patients with Bell's palsy had received NFLU, compared with 1.1% of controls, resulting in an odds ratio of 84.0. Even at the lowest end of the confidence interval, 13 excess cases of Bell's palsy would be seen for each 10,000 NFLU vaccinees within 3 months after vaccination.

From 2000-2001, Switzerland used an inactivated virosomal-subunit influenza vaccine (Nasalflu®), but this is no longer in clinical use. The USA has approved a different vaccine, utilizing a cold-adapted live attenuated vaccine. ■

Topiramate for Migraine Prevention

Source: Brandes JL, et al. *JAMA*. 2004;291(8):965-973.

SOME PATIENTS REMAIN DISSATISFIED with or intolerant of available migraine treatments. Early studies have found that topiramate (TOP), an antiepileptic agent, is efficacious for migraine prevention. Although there are numerous potential pathways that might explain the efficacy of TOP, such as inhibition of voltage-gated sodium channels, most recently it has been suggested that modulation of trigeminovascular signaling may be the primary mechanism of action in migraine.

Patients suffering migraine with or without aura (n = 483) were randomized to TOP 50 mg/d, 100 mg/d, or 200 mg/d or placebo and followed for 18 weeks. The primary end point was change in migraine headache frequency per month.

At baseline, patients suffered 5-6 headaches per month, which was statistically significantly reduced by 2-3 headaches per month. with 100 mg/d and 200 mg/d TOP (but not by the 50 mg/d dose) Similarly, the number of days per month with headache was cut by 2.5-3 days/month at doses of 100 mg/d or 200 mg/d.

The most common adverse events associated with topiramate were paresthesia (50%), fatigue (14%) and anorexia (13%), but these uncommonly led to drug discontinuation. There were no serious adverse

events, and modest changes in serum bicarbonate and chloride as seen in previous populations were also seen here. These data are encouraging for the clinical applicability of topiramate in patients who are not suitable candidates for other migraine treatments. ■

Computed Tomographic Colonography (Virtual Colonoscopy)

Source: Cotton PB, et al. *JAMA*. 2004;291:1713-1719.

SCREENING FOR COLON CANCER (CCa) has not reached the same level of popular adherence as seen with, for instance, prostate cancer screening by PSA. Although colonoscopy (COL) is highly effective for the detection and elimination of malignant precursors, only about half of the COL-eligible population undergoes the procedure. It has been anticipated that if a highly discriminating screening tool, with less invasive properties than COL, were available, a greater number of persons would adopt it. Virtual colonoscopy (vCOL) is a candidate for such a tool.

vCOL is performed by helical CT scanning of the air-distended (or carbon dioxide distended) colon, after a traditional bowel preparation. Lesions discerned at vCOL then require tissue definition by COL. If vCOL were sufficiently accurate, and well tolerated by patients, it could eliminate many "unnecessary" colonoscopies.

This multicenter study enrolled 617 subjects who underwent both COL and vCOL within a 2-hour interval, of whom 600 ultimately satisfactorily completed both investigations. Examinations were performed by experienced endoscopists and radiologists.

For lesions 10 mm or greater in size, the sensitivity of vCOL was 55%. For smaller lesions (6-10 mm), vCOL sensitivity was 39%. These results are slightly less favorable than seen in some other trials; Cotton and colleagues comment that this may reflect a higher experience level of radiologists in other trials, despite their inclusionary criteria for radiologist competency. These data suggest that current vCOL techniques are not yet sufficiently evolved to recommend supplanting more traditional methods. ■

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Ejaculation Frequency and Subsequent Risk of Prostate Cancer

Source: Leitzmann MF, et al. *JAMA*. 2004;291:1578-1586.

PROSTATE CANCER (pCA) HYPOTHETICALLY could be related to sexual activity. For instance, if men who seek sexual activity more often have higher testosterone levels, and such levels were associated with greater risk of pCA, a sexual acitivity-pCA relationship could be hypothesized. Similarly, it has been theorized that ejaculating with reduced frequency might expose prostatic tissues to carcinogenic components in retained prostatic secretions.

The Health Professionals Follow-up Study began in 1986 enrolling 51,229 health professionals age 40-75. In 1992, a questionnaire solicited ejaculatory history, asking participants to recall the average monthly number of ejaculations at ages 20-29, 40-49, and in the previous year. Frequency categories (ejaculations per month) were broken down into 1-3, 4-7, 8-12, 13-20, and > 21.

In age-adjusted and multivariate analysis, an 11% lower relative risk of pCA was found in the highest tier of monthly ejaculations (21 or greater). For all lesser ejaculatory frequencies studied, there was no discernible relationship (positive or negative). When specifically looking at advanced pCA, there was a trend towards increased risk among those with high ejaculation frequency. Except for these subgroups, there was no demonstrable overall relationship between ejaculatory frequency and pCA. ■

Different Combinations of Bupropion SR dose and Behavioral Treatment for Smoking Cessation

Source: Javitz HS, et al. *Am J Manag Care*. 2004;10:217-226.

THE SINGLE MOST EFFECTIVE PHARMACEUTICAL intervention which results in sustained smoking cessation is bupropion (BUP). The most often-used treatment regimen requires BUP 150 mg/d for 3 days, followed by 300 mg/d (usually divided b.i.d.) for up to 12 weeks. The added benefit of behavioral counseling or nicotine replacement when used in conjunction with BUP is less clear, although it is commonplace for these tools to be used concomitantly.

Although the favorable effects of BUP for smoking cessation have been consistent, these conclusions are drawn from research centers that might not reflect typical clinical practice settings. Javitz and colleagues evaluated BUP (150 mg or 300 mg QD, sustained release) with 1 of 2 brief counseling interventions: multiple followup calls from a smoking cessation counselor (called 'PTC' in the article) or an automated questionnaire series during followup (called 'TM' in the article). Either brief counseling intervention could readily be applied in the typical ambulatory setting.

At 12 months, the cessation rates for 300 mg BUP daily were slightly higher than, but similar to 150 mg BUP daily (28.5% vs 22.5%). The more intensive, personalized behavioral intervention (PTC) was also associated with greater mean cessation rates. The authors conclude that the lower BUP dose is more cost effective than 300 mg BUP, with modestly lesser efficacy. ■